MICHIGAN MEDICINE

January 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 81, Number 3

Designer genes

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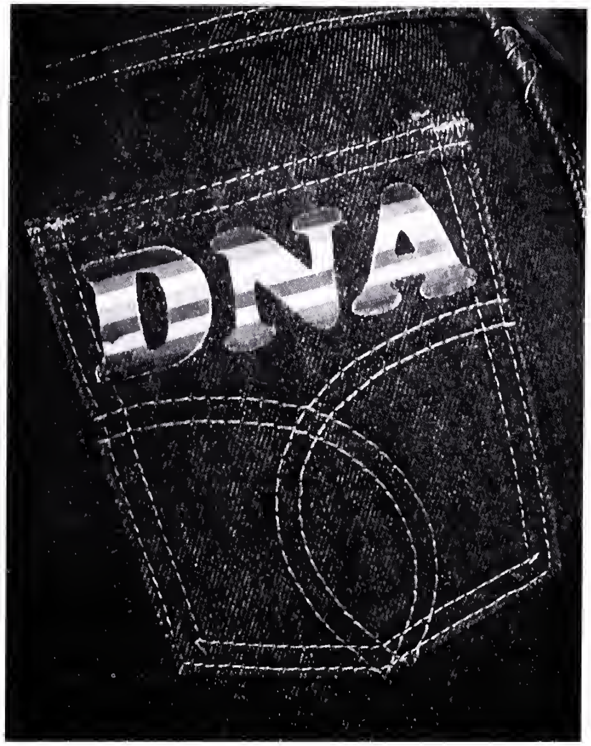

“DESIGNER GENES”

1982 Michigan Conference on Maternal and Perinatal Health

April 14-15, 1982
Grand Center/Amway Grand Plaza
Grand Rapids

April 14

New Horizons in Perinatal Diagnoses
Michael M. Kaback, MD, UCLA
Prenatal Genetic Risk Assessment and Counseling
Elizabeth J. Thomson, RN, University of Iowa
Evaluation of Fetal Wastage
Sherman Elias, MD, Northwestern University
Recent Advances in Human Cytogenetics
James V. Higgins, PhD, MSU
Prenatal Diagnosis of Congenital Anomalies by Ultrasound
Peter Grannum, MD, Yale University
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Diagnostic Evaluation of the Dysmorphic Child
Murray Feingold, MD, Tufts University

April 15

Population Screening and Perinatal Diagnosis for Metabolic Abnormalities
Michael M. Kaback, MD, UCLA
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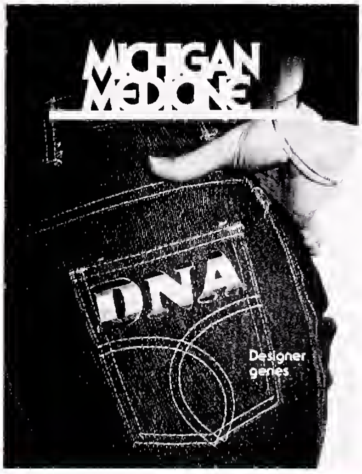
Teratogens: Environmental Hazards for Fetal Development
James W. Hanson, MD, University of Iowa
Michigan Genetic Disease Program
William D. Young, PhD, MDPH, Lansing
Counseling Process in a Genetics Clinic
Diane Baker, MS, U-M
The Law and Genetics
Margery W. Shaw, MD, JD, Health Law Institute, Houston
Ethical Considerations in Genetic Screening
Joseph Fletcher, STD, D. Litt., University of Virginia

MARK YOUR CALENDARS NOW!



"Designer genes" is the upbeat theme of the distinguished faculty assembling for the 1982 Michigan Conference on Maternal and Perinatal Health, April 14-15, in Grand Rapids. For details, see page 4. **(Photo by Mert Scholten)**

MICHIGAN MEDICINE
January 1982, Volume 81, No. 3

Special report

4 The dynamic field of medical genetics, as it applies to the prenatal patient and the neonate, is the theme of the 1982 Michigan Conference on Maternal and Perinatal Health April 14-15 in Grand Rapids. The conference, which MSMS organizes and administrates with the help of several other interested groups, is the subject of this months' special report. You will find an overview of the conference program, the schedule and registration form, and sketches of the speakers and their topics; Gerald B. Holzman, MD

Features

12 MSMS Physician Legislative Network a chance to see what goes on in Lansing; Mark Campbell, MD

21 Profile of Sen. Kerry Kammer as gubernatorial candidate; Willah Weddon

24 Cable TV show, travelers' self-help brochure lead current MSMS public service efforts; Elmer White

30 Photo highlights of MSMS Annual Scientific Meeting; Mert Scholten

41 New WSU School of Medicine dean wants to improve research, residency programs; Shelton Reece

44 MSMS conference on stress provides insights; Kim Dean

54 Michigan Medical Arbitration Program saves time; Deborah Zannoth

Departments

3 Letters

10 News: Sheri W. Greenhoe

28 Issues and angles: New feature on medical news developments, this time the laboratory referrals bill; Dwight E. M. Angell

32 MSMS/A; Cheri Calvelo

46 Finances: The money purchase retirement plan; David R. Nadeau

48 Medical newsfronts

50 Category I courses

52 Meetings

58 Views: MDPAC; Harvey Halberstadt, MD

62 Deaths

63 Classified ads

64 Photo feature: Assembling the Medicaid project work team; Richard Wesley

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Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

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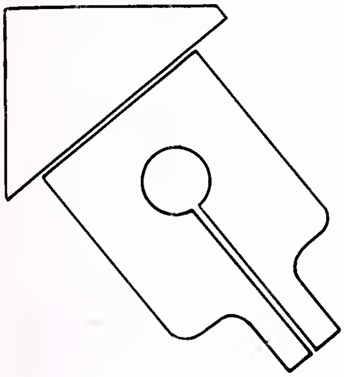
LETTERS



Child car seats

Most of us are aware of the passage of Public Act 117, 1981, requiring that each driver transporting a child under age four in a motor vehicle shall properly secure each child in a safe child restraint system. Our knowledge varies considerably once we stray from the basic fact noted in the initial sentence.

As health professionals, it is incumbent upon each of us to alert our patients, our friends and relatives, and our associates to the following:

1. This law takes effect April 1, 1982. We cannot become complacent about the potential saving of young lives if the public is made aware of this law.

2. More children are hurt or killed each year from automobile crashes than from any disease or other type of accident. In 1980, over 3,350 Michigan children under age four were injured while riding as passengers in cars.

3. Pediatricians, obstetricians, and family physicians must encourage mothers to obtain a safe child restraint *before* leaving the hospital. "Make baby's first ride a safe ride."

4. Write a "prescription" for a child restraint appropriate to the child's age. When the family is preparing baby's room, shouldn't a safe child restraint be part of the furnishings? Many regions have a loan service for those who cannot afford to purchase.

Your encouragement may avert one of the most tragic events to occur in any family, the death or injury of a child.

For information on appropriate seats or restraints, please contact: Office of Highway Safety Planning, 7150 Harris Drive, Lansing, 48913, or call (517) 322-1942.

Maurice S. Reizen, MD, Chief
Bureau of Personal Health Services
Michigan Department of
Public Health
Lansing

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IC System	35
INFOMAX	57
International Diamond	33
Medical Protective	60
MDPAC	58
Michigan Physicians Mutual Liability Company	11
MSMS Maternal Health Conference-	IFC
National Bank of Detroit	25
National Medical Enterprises	59
Physicians Insurance Company of Michigan	23
Reed Office Systems	60
Roche	IBC, BC
Stratton Cheeseman	55
Troy Biologicals	61
University Microfilms	26
Upjohn	18, 19
Watkins, Ross, Baines & Lamps	59

Doctor Gagliardi

Please be advised that Carl A. Gagliardi, MD was appointed to the board of directors of the New Michigan Council on Graduate Medical Education. Your publication of November 13, 1981, stated that he was appointed a delegate, which is incorrect.

Yours truly,
Mary Agnes Clickner
Secretary to the Director of Medical Education
Oakwood Hospital
Dearborn

Attitude survey

It was a pleasure to read the research report, "Attitudes Toward Health Care Issues," which appeared in the October 1981 issue of *Michigan Medicine*. With studies such as this one, our understanding of differences in health care attitudes among providers and consumers is much improved.

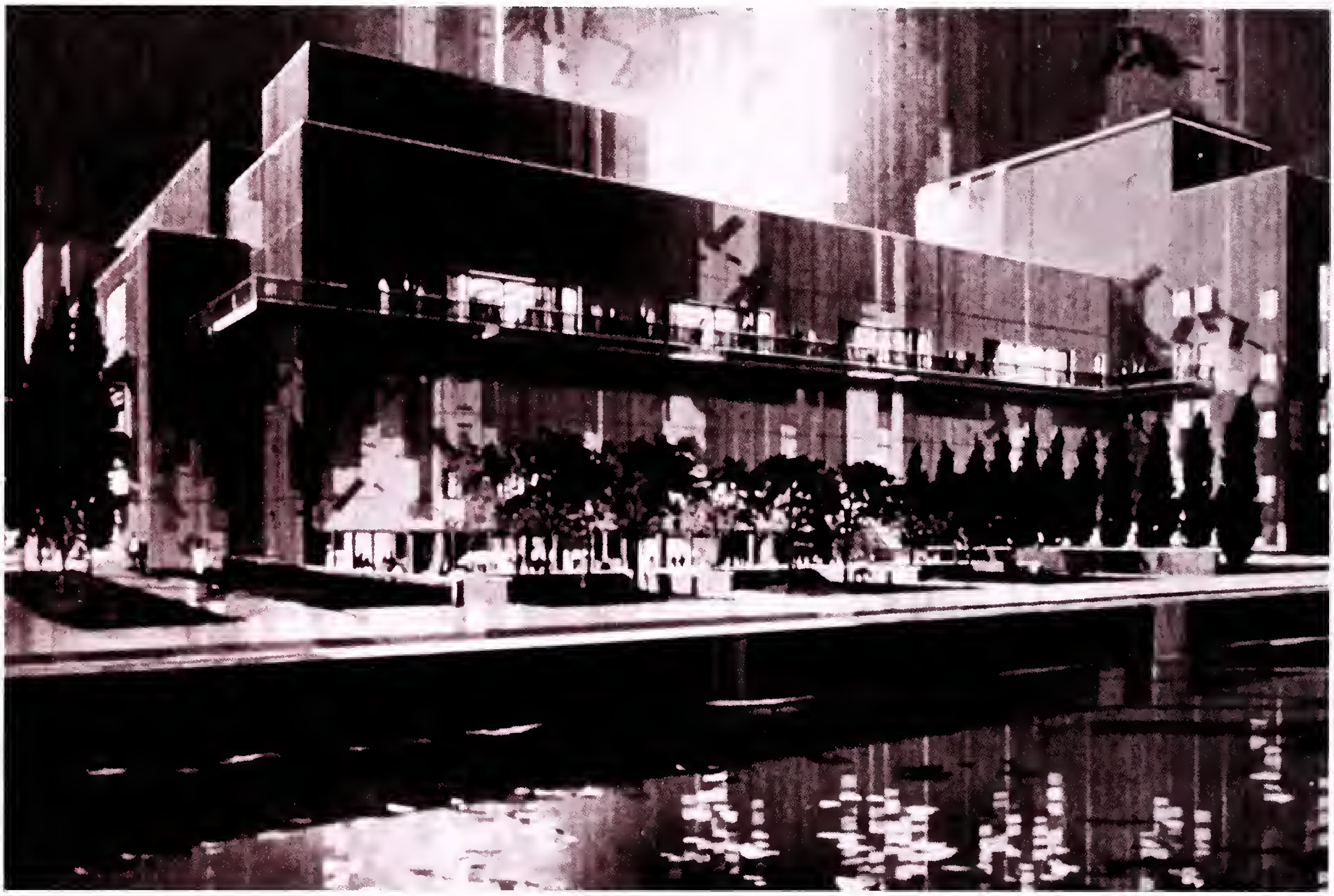
I will be happy to share this report with my medical care organization students in the Institute for Personal and Career Development of Central Michigan University. The findings should provide for interesting discussion and perhaps insight into health care utilization issues. Hopefully, the Medical Society will conduct other studies like this in the future.

Sincerely,
Ernest M. Hammel, PhD
Executive Director
Oakland Health Education Program
Rochester

SPECIAL REPORT

Distinguished faculty of genetics experts scheduled for Maternal Health Conference

By Gerald B. Holzman, MD
East Lansing



Grand Rapids new Grand Center convention hall, scene of the April 14-15 Conference on Maternal and Perinatal Health.

Nowhere are the accelerating changes in medical science more evident than in the field of genetics as it applies to the prenatal patient or the neonate.

A technology discussed on a theoretical level a few years ago is available today to the physician and other members of the health care team. The time interval from concept to practical application is ever shortening.

Doctor Holzman is co-chairman of the Michigan Conference on Maternal and Perinatal Health.

You can learn about these advances in genetics at the 21st Annual Michigan Conference on Maternal and Perinatal Health planned for the new Grand Center/Amway Grand Plaza in Grand Rapids, April 14-15.

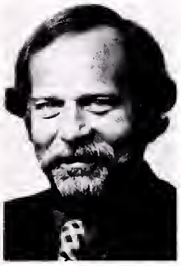
The conference Planning Committee feels fortunate to have obtained a faculty of international experts to present its program. Their names should be familiar since they have published extensively in the field. The following describes the subjects covered.

Jacquelyn R. Roberson, MD, director of the Perinatal Diagnostic Program at Henry Ford Hospital's Medical Genetics and Birth Defects Center, will moderate the first session. Henry Ford Hospital has the distinction of being the pioneer in the field of genetics in Michigan.

The conference opens with an overview of what is new in perinatal genetics. This leads into discussions about prenatal risk assessment and counseling, evaluation of fetal wastage, and recent advances in human cytogenetics. Registrants then will learn about diagnosing prenatal con-

Continued on page 6

Here are speakers, topics and abstracts of Maternal Health Conference talks


Kaback

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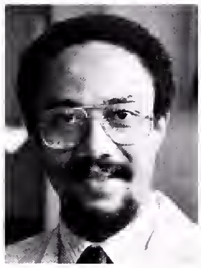
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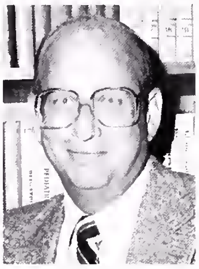

Nadler

In the order of their presentations

- **Michael M. Kaback, MD**, professors, Departments of Pediatrics and Medicine, UCLA School of Medicine; associate chief, Division of Medical Genetics, Harbor-UCLA Medical Center, Los Angeles

"New Horizons in Perinatal Diagnoses"

Genetics have enjoyed a history of exciting growth which in the next few years should prove even more valuable to practicing physicians. In prenatal diagnosis the use of maternal blood to obtain fetal cells samples should become a reality. If amniotic fluid cells are fused to cells of different origin from different species, the genes of interest may be, so to speak, turned on.

Large scale screening of high risk populations are likely to be more available. New techniques of chromosomal banding, prophase banding, have uncovered new chromosomal defects. Gene mapping, which is linking of readily detectable gene markers with serious abnormalities, should help patients make informed reproductive decisions. Finally, and most exciting, is the evaluation of the DNA by endonucleases in the detection and ultimate treatment of genetic diseases.

- **Elizabeth J. Thomson, RN, BSN**, clinical coordinator, Regional Genetic Consultation Service, Department of Pediatrics, University of Iowa Hospitals, Iowa City

"Prenatal Genetic Risk Assessment and Counseling"

When a family/maternal history indicates there is an increased risk of having a child born with a birth defect or genetic disorder, several items must be discussed. It is important to review the couple's actual risk, what type of prenatal diagnosis is available, and what the procedure involves, including a description of the limitations, cost, and risks of the procedure.

This discussion will allow the couple/woman to make an informed decision regarding benefits vs. risks of the prenatal diagnosis available. It also will assist in opening the lines of communication between the couple/woman and the health care professional.

- **Sherman Elias, MD**, co-director, Clinical Genetic Services; assistant professor, Obstetrics and Gynecology, Northwestern University Medical School, Chicago

"Evaluation of Fetal Wastage"

Chromosomal abnormalities and genetic defects represent significant factors that can be identified in the etiology of fetal wastage and recurrent abortions. Careful and properly performed pathological evaluation may be useful in future counseling.

Consideration of systemic causes, endocrine factors, uterine anomalies and drug exposure is important. Nutritional counseling and psychological support are also necessary for proper care of patients with poor obstetrical histories.

- **James V. Higgins, PhD**, professor, Department of Pediatrics/Human Development and Zoology, Michigan State University, East Lansing

"Recent Advances in Human Cytogenetics"

New methods of chromosomal analysis have expanded our evaluation of handicapped and dysmorphic children, couples with repeated pregnancy losses and abortuses and stillborn children. We have gone from looking to the individual chromosome to looking at DNA.

- **Peter Grannum, MD**, assistant professor and director of medical studies, Department of Obstetrics and Gynecology, Yale University School of Medicine, New Haven

"Prenatal Diagnosis of Congenital Anomalies by Ultrasound"

New imaging methods which promise help in screening for defects and major organ anomalies such as limb dysplasias, neurological abnormalities, etc., will be discussed.

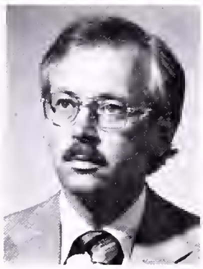
- **Henry L. Nadler, MD**, dean and professor of pediatrics, Wayne State University School of Medicine, Detroit

"Recognition and Diagnosis of Sick Infants with Inborn Errors"

Inborn errors of metabolism presenting in the newborn period are generally devastating, resulting in permanent mental retardation and significant mortality. Making the diagnosis early and instituting appropriate therapy not only can save life, but also can improve the quality of life.

Therefore, a high-index of suspicion is necessary for early recognition of these metabolic problems. This session will discuss presenting signs, clinical features, laboratory tests, and therapeutic regimens in

Feingold



Hanson

Young

current use for the more common in-born errors of metabolism.

- **Murray Feingold, MD**, professor of pediatrics, Tufts University School of Medicine; chief, Genetic and Birth Defects Division, Tufts — New England Medical Center, Boston

"Diagnostic Evaluation of the Dysmorphic Child"

The session on dysmorphology will seek to provide a useful method of classification of common dysmorphic syndromes, outline a broad practical initial diagnostic approach to the dysmorphic infant, and illustrate representative dysmorphic states with appropriate slides.

- **Michael M. Kaback, MD**, professor, Departments of Pediatrics and Medicine, UCLA School of Medicine; associate chief, Division of Medical Genetics, Harbor-UCLA Medical Center, Los Angeles

"Population Screening and Perinatal Diagnosis for Metabolic Abnormalities"

This session will include a brief overview of newborn screening for in-born errors of metabolism and hypothyroidism. Current status of screening for the carrier state of Tay-Sachs, Sickle Cell Anemia, and certain X-linked disorders will be discussed.

- **James E. Haddow, MD**, associate medical director, Foundation for Blood Research, Scarborough, Maine

"Serum Alpha Fetaprotein Screening"

The significance of an elevated amniotic fluid alpha fetoprotein will be explored both in the high risk patient, who has given birth to a child with neural tube defect previously, and the low risk patient who is having an amniocentesis for other indications.

The usefulness of serum alpha fetoprotein determinations in the detections of neural tube defects will be examined and the characteristics of a mass screening program described.

- **James W. Hanson, MD**, Division of Medical Genetics, Department of Pediatrics, University of Iowa Hospitals and Clinics, Iowa City

"Teratogens: Environmental Hazards for Fetal Development"

Human genetics is the study of human variability. Not all sources of

Objectives of the conference

This Conference will review and analyze the clinical applications of emerging techniques and knowledge in genetics, to include the following:

1. Identification of preconceptual and perinatal risk factors for genetic disease.
2. Risk assessment and counseling.
3. The Michigan Genetic Disease program.
4. Analysis of fetal loss relative to genetic risk.
5. Identification of the newborn with chromosomal, dysmorphic, or

6. Legal and ethical dilemmas.

genital anomalies, using ultrasound, about the early recognition and diagnosis of inborn errors, and about the evaluation of the dysmorphic child.

The second day of the conference program includes presentations on population screening and the perinatal diagnosis of metabolic abnormalities, and on alpha fetoprotein screening. Later that morning there will be a lecture about teratogens, environmental hazards for fetal development technology and services, and ethical considerations.

Registrants will hear about the federally-supported Michigan Genetic Disease Program and about the counseling process in a genetic clinic. The conference will end on a legal and ethical note, the field of perinatal genetics being explored by experts in both disciplines.

Not only will those in attendance find this conference an exceptional learning experience, but also their attendance will be enhanced by the excellent meeting facilities of the new Grand Center in Grand Rapids. The headquarters hotel is the Amway Grand Plaza — the former Pantlind Hotel which has been completely renovated and restored to its original elegance.

The 1982 Michigan Conference on Maternal and Perinatal Health has been approved by MSMS for 11 hours of Category I Continuing Medical Education Credit, and for 11 hours of Prescribed Credit by the American Academy of Family Physicians. In addition, it has been approved for 12.9 CEU contact hours by the Michigan Nurses Association.

Approximately 1,000 physicians, nurses, medical and nursing students, and other health care professionals annually attend this conference designed to improve maternal and perinatal care. The Planning Committee looks forward to this record being surpassed in 1982.

The 1982 Conference is a joint effort by eight groups. While MSMS coordinates the program, makes physical arrangements, handles the publicity and is in charge of registration, the program represents the collective effort of all participating organizations. These are the MSMS; Michigan Academy of Family Physi-

Continued on page 8

Here is Maternal Health Conference program and registration form

Grand Center, Grand Rapids

Wednesday Morning, April 14

8:45 a.m. "New Horizons in Perinatal Diagnoses" — Michael M. Kaback, MD, professor, Departments of Pediatrics and Medicine, UCLA School of Medicine; associate chief, Division of Medical Genetics, Harbor-UCLA Medical Center, Los Angeles

9:30 a.m. "Prenatal Genetic Risk Assessment and Counseling" — Elizabeth J. Thomson, RN, BSN, clinical coordinator, Regional Genetic Consultation Service, Department of Pediatrics, University of Iowa Hospitals

10:30 a.m. "Evaluation of Fetal Wastage" — Sherman Elias, MD, co-director, Clinical Genetic Services; assistant professor, Obstetrics and Gynecology, Northwestern University Medical School

11:15 a.m. "Recent Advances in Human Cytogenetics" — James V. Higgins, PhD, professor, Department of Pediatrics/Human Development and Zoology, Michigan State University

Wednesday Afternoon, April 14

2:15 p.m. "Prenatal Diagnosis of Congenital Anomalies by Ultrasound" — Peter Grannum, MD, assistant professor and director of medical studies, Department of Obstetrics and Gynecology, Yale University School of Medicine

2:45 p.m. "Recognition and Diagnosis of Sick Infants with Inborn Errors" — Henry L. Nadler, MD, dean and professor of pediatrics, Wayne State University School of Medicine

4:00 p.m. "Diagnostic Evaluation of the Dysmorphic Child" — Murray Feingold, MD, professor of pediatrics, Tufts University School of Medicine; chief, Genetic and Birth Defects Division, Tufts-New England Medical Center, Boston

Thursday Morning, April 15

8:45 a.m. "Population Screening and Perinatal Diagnosis for Metabolic Abnormalities" — Michael M. Kaback, MD, professor, Departments of Pediatrics and Medicine, UCLA School of Medicine; associate chief, Division of Medical Genetics, Harbor-UCLA Medical Center

9:30 a.m. "Serum Alpha Fetaprotein Screening" — James E. Haddow, MD, associate medical director, Foundation for Blood Research, Scarborough, Maine

10:30 a.m. "Teratogens: Environmental Hazards for Fetal Development" — James W. Hanson, MD, Division of Medical Genetics, Department of Pediatrics, University of Iowa Hospitals and Clinics

11:15 a.m. "Michigan Genetic Disease Program" — William D. Young, PhD, Genetics Program Coordinator, Michigan Department of Public Health

Thursday Afternoon, April 15

1:30 p.m. "Counseling Process in a Genetics Clinic" — Diane Baker, MS, genetic consultant, Michigan Department of Public Health, and University of Michigan Medical Center

2:00 p.m. "The Law and Genetics" — Margery W. Shaw, MD, JD, professor of medical genetics, acting director, Health Law Institute, Houston

2:45 p.m. "Ethical Consideration in Genetic Screening" — Joseph Fletcher, STD, D. Litt., visiting scholar in medical ethics, School of Medicine, University of Virginia, Charlottesville

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The program is approved for 11 hours of CME Category I credit; accepted for 11 prescribed hours by The American Academy of Family Physicians, and approved for 12.9 CEU contact hours by the Michigan Nurses Association.

Advance Registration

Complete and mail to the Michigan Conference on Maternal and Perinatal Health, Box 950, East Lansing, MI 48823

Name

Address

City Zip

Please check one:

Physician	RN	LPN	Student	Other
☐	☐	☐	☐	☐

Registration Fee:		Physician	Nurse	Other	Student/House Officer
Please Check	Wednesday Sessions	☐ $20	☐ $15	☐ $15	☐ No Charge
	Thursday Sessions	☐ $20	☐ $15	☐ $15	☐ No Charge
	Total	$	$	$	$ (none)

Make checks payable to Michigan State Medical Society

Baker

human variability are heritable. A wide variety of environmental factors including infectious agents (Viruses, parasites, and bacteria), physical agents (heat, radiation and mechanical forces), drugs and chemicals (prescription drugs, environmental chemicals, non-prescription drugs), and maternal, metabolic and genetic disorders (maternal diabetes mellitus, maternal myotonic dystrophy), have been implicated as having an adverse effect on fetal growth and development. These factors represent avoidable causes of birth defects and as such their recognition is uniquely important for physicians and other health care providers. This discussion will include an approach to the assessment and evaluation of reports on teratogenic agents. Clinical aspects of common known teratogenic agents will be reviewed.

- **William D. Young, PhD,** genetics program coordinator, Michigan Department of Public Health, Lansing

"Michigan Genetics Disease Program"

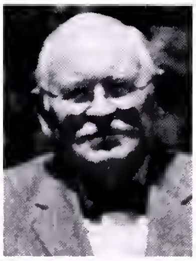
This discussion will include a description of the relationship between the Michigan Departments of Public and Mental Health and the major genetic service units in the state; the genetic service delivery network including, location of satellite and hospital based clinics; indications for and method of referral, and cost for service.

- **Diane L. Baker, MS,** genetic consultant, Michigan Department of Public Health, Lansing, and University of Michigan Medical Center

"Counseling Process in a Genetics Clinic"

The genetic counselor explores the dynamics of a family in which a genetic defect has occurred or is anticipated. The counselor attempts to deal in a non-directive manner with the range of cognitive and emotional responses to genetic disease. Available options are reviewed with the family and referrals made to appropriate community resources.

Shaw



Fletcher

- **Margery W. Shaw, MD, JD,** professor of medical genetics, acting director, Health Law Institute, Houston

"The Law and Genetics"

The increasing sophistication of genetic diagnosis has created legal issues which now are affecting utilization of genetic services. The doctor/patient contract and the counselor/counselee relationship will be explored. The legal "standard of care" for genetic testing, diagnosis, and disclosure of risks and reproductive alternatives will be discussed in the context of malpractice cases involving genetic and chromosomal disorders.

- **Joseph Fletcher, STD, D.Litt.,** visiting scholar in medical ethics, School of Medicine, University of Virginia, Charlottesville

"Ethical Considerations in Genetic Screening"

A general background statement on the sorts of ethical dilemmas raised by new technology in genetic screening and engineering, followed by a discussion about the ethical position on the appropriate use of technology and genetic intervention. The speaker will distinguish the rational use of technology from blindly being influenced by a technological imperative, and defend the choice of "rationality" as a guiding principle (e.g., does maximizing rationality necessarily maximize human happiness?).

cians; Michigan Chapter, American Academy of Pediatrics; Michigan Department of Public Health; Michigan Nurses Association; Michigan Section, Nurses Association, American College of Obstetricians and Gynecologists, District V; Michigan Society of Obstetricians and Gynecologists; and Perinatal Association of Michigan.

Members of the Planning Committee are: Gerald B. Holzman, MD, Co-chairman, East Lansing; John W. Hallitt, MD, Co-chairman, Flint; Robert C. Borer, Jr., MD, Detroit; C. Arch Brown, MD, Flint; Laurence Bruggers, MD, Saginaw; Mary M. Conklin, RN, Lansing; Miriam S. Daly, MD, Albion; Marianne R. Glassanos, RN, Ann Arbor; Joan Hall, RN, Grosse Pointe; John V. Hartline, MD, Kalamazoo; James V. Higgins, PhD, East Lansing; Mary J. Kokosky, MD, Dearborn; Gretchen Landenburger, MS, East Lansing; Federico Mariona, MD, Detroit; Dorothy A. Porter, MD, Lathrup Village; Mary A. Scoblic, RN, Lansing; Kenneth J. VanderKolk, MD, Grand Rapids; Donald Waterman, MD, Grand Rapids; Lester Weiss, MD, Detroit; William I. Young, PhD, Lansing; Henry L. Nadler, MD, Consultant, Detroit; Lee B. Stevenson, MD, ex officio, Southfield; and Katie Brewbaker, conference coordinator, MSMS staff.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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NEWS

By Sheri W. Greenhoe
East Lansing

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Alfred B. Swanson, MD, Grand Rapids, was chairman of the Hand Surgery Section at the 15th World Congress of the International Society of Orthopaedic Surgery and Traumatology, held in Rio de Janeiro in September. ... the Community Health Center of Branch County honored Coldwater's **Harold J. Meier, MD,** at a recent luncheon commemorating his retirement from a medical career that spanned 52 years. ... Former Wayne County Medical Society Auxiliary President **Alice Haidostian,** of Bloomfiled Township is credited with initiating the idea for the $200,000 production of an Armenian opera which ran at the Detroit Music Hall last month. ... **Francis Horvath, MD,** Lansing, was elected secretary-treasurer of the Michigan Society of Internal Medicine during that organization's annual meeting at Boyne Highlands. ... **William A. LeMire, III, MD,** Escanaba, was presented with a golden timepiece by Abbott Laboratories recently in recognition of the doctor's 50 years of outstanding service and dedication to medicine. ... OB/GYN specialist **Carolyn Hoekstra, MD,** was spotlighted by the Albion Business and Professional Women's Club during National Business Women's Week. ... **John G. Weigenstein, MD,** East Lansing, professor of medicine and chief of emergency medicine in MSU's College of Human Medicine, has been named president-elect of the American Board of Emergency Medicine. Doctor Weigenstein is the founder of the American College of Emergency Physicians. ... The Michigan Chapter of the American College of Physicians recently recognized seven members for loyalty and longstanding membership: **John D. Littig, MD, FACP,** Kalamazoo; **Alvin E. Price, MD, FACP,** Detroit; **William S. Reveno, MD, FACP,** Southfield; **Lutfi M. Sa'Di, MD, FACP,** Romeo; **Joseph H. Shaffer, MD, FACP,** Birmingham; **Richard C. Connelly, MD, FACP,** Grosse Pointe Park; and **John V. Fopeano, MD, FACP,** Kalamazoo. ... **Paul Stein, MD,** director of Henry Ford Hospital's cardiovascular research lab, has been awarded $90,000 for continuing studies of the assessment of cardiac valves by analysis of heart sounds. **Pedro Cortes, MD,** also on the HFH staff, has received a $114,123 three-year grant from the National Institute of Arthritis, Metabolic and Digestive Diseases to support his study of metabolic abnormalities leading to diabetic renal disease. ... **Calvin Ervin, MD,** of the Detroit Medical Society, was elected to a one-year term on the Comprehensive Health Planning Council of Southeastern Michigan's Executive Committee. Also elected to the committee were **John Waller, Jr., MD, DPH,** director of the Detroit Health Department; and **Delmar Mahrt, MD,** representing the Oakland County Medical Society. Doctor Mahrt also was awarded the American Cancer Society's National Divisional Award recently. ... **Honorato Barrios, MD,** Hancock, is spending four to six weeks in his native Peru to visit a number of rural and urban hospitals to teach and perform surgery for people who lack modern medical care. Doctor Barrios makes this trip every two years. ... **Marjorie Peebles-Meyers, MD,** Detroit, was appointed by Governor Milliken to the Judicial Tenure Commission. Doctor Peebles-Meyers is in charge of the medical unit at Ford Motor Company. ... A $500 check to help support the premedical program at Northern Michigan University was presented by **J. Michael Coyne, MD,** in behalf of the Marquette-Alger county Medical Society and its Auxiliary. The group has made a contibution to the program for four consecutive years. ... **Arthur L. Foley, III, MD,** MSU anatomy professor, has received an honorary membership in the College of Human Medicine Alumni Association. He has been honored several times by graduating MD classses as "best teacher" among fulltime faculty. His honorary membership is the second awarded: the first went to the school's founding dean. .. Two Midland physicians, **Martin J. Ittner, MD,** and **Richard H. Howell, MD,** have been honored by the American Academy of Family Physicians for 25 years of service in the nation's largest medical specialty organization. Also honored by ACEP was South Haven doctor **John H. Kleber, MD.** ... **Reed O. Dingman, DDS, MD,** professor emeritus of plastic surgery at the U-M Medical School and founder of the school's division of plastic surgery, has been awarded the Distinguished Alumni Award from the U-M Medical Center Alumni Society. ... **John A. Mulder, MD,** a resident at St. Mary's Hospital in Grand Rapids, won the award in the resident/student category for his paper, "Patient Compliance to Individualized Home Exercise Program" at the American Academy of Family Physician's annual meeting in Las Vegas.

Ms. Greenhoe is editorial secretary to *Michigan Medicine.*

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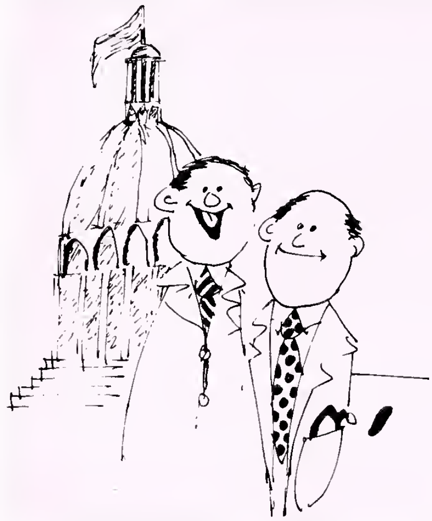
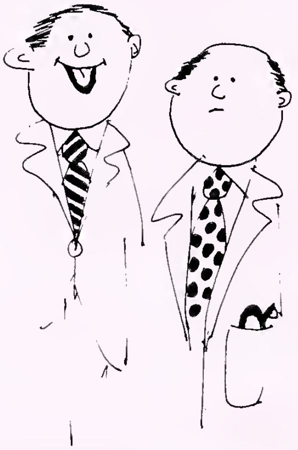
MSMS Physician Legislative Network offers MSMS members an opportunity

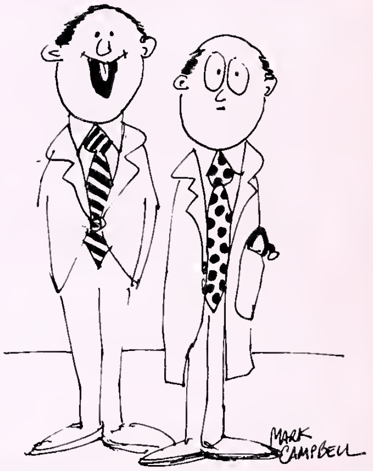
By Mark A. Campbell, MD
Grand Rapids



Today the legislature voted on the new medical practice act.



I understand that now teachers will take over patient education; lawyers will do patient counseling; pharmacists will begin prescribing, seamstresses will do all surgery.



. . . and the doctors will be expected to complete the insurance forms.

While collecting some thoughts about my recent trip to the State Capitol as part of an MSMS "Physician for a Day" program, I was reminded of some lines attributed to Edmund Burke:

> "*The only thing necessary for the triumph of evil is for good men to do nothing.*"

As one of the highest educated groups in America, as a profession of concerned physicians, and as caring individuals, it is vitally important that we devote attention to what goes on in our lawmaking bodies.

Citizens who become actively involved in our legislative process have the opportunity to shape events to some extent; but those who remain uninvolved can affect little.

Doctor Campbell is an oncologist, and a cartoonist.

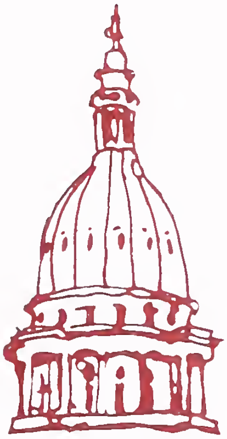
The day at the Capitol exposed me first hand to our legislative process, gave me a better understanding of its incredible complexity, and how it is a constant force for change. Forces for change arise both from within the governmental bureaucracy and from special interest groups outside government.

On the floors of the House of Representatives and the Senate on the day I observed them, there was a great deal of activity. A large number of bills were being presented, processed, re-presented, debated, re-debated, and finally voted upon. The activity reminded me more of the chaos associated with the Stock Exchange than of an audience listening attentively to debators. The complexity seemed to foment quickly, orderly and with surprising calm.

It became clearer to me that the "calm" was the product of hours and hours of seemingly endless committee meetings, luncheons, private conversations, handshakes, arm twists, back slaps, promises, threats, whispered chats, phone calls, and personal pleadings from one source to another. Eventually the complex aspects to each issue had to be reduced to a simple vote — "Yea" or "Nay".

The question for us isn't whether the legislative system is "good" or "bad." It is rather, as the continuing process of change goes on, will this change be subject to our appropriate, important, and strong input? Or will it go on in a vacuum of effort by physicians who are "too busy?" And how many of us will be among the "good men" who do nothing?

Here's your opportunity, Doctor, to join MSMS Physician Legislative Network



Many MSMS members are acquainted with important legislators and government officials and are willing to employ this acquaintance to advance the legislative efforts of the medical profession.

The MSMS Department of Government Relations maintains a list of these members and calls upon them for assistance when the need arises.

If you are willing to participate in this program, either "back home" or in Lansing, MSMS invites you to fill in the form on the other side of this sheet, as appropriate. This information will be held confidential and used only by MSMS in its contacts with you.

______ I'm interested in working with the "MSMS Physician Legislative Network"
NAME:______________________________
ADDRESS:______________________________
PHONE # HOME:__________ OFFICE:__________ HOSP:__________
TYPE OF PRACTICE SETTING:__________ SPECIALTY:__________
HOSPITAL AFFILIATION IF APPLICABLE:______________________________
MEMBERSHIP IN SPECIALTY SOCIETY:______________________________
OFFICES HELD, COMMITTEE INTERESTS:______________________________
____

PLEASE INDICATE THE DISTRICTS IN WHICH YOU ARE REGISTERED TO VOTE:
CONGRESSIONAL:__________ STATE SENATE DISTRICT:__________
STATE HOUSE DISTRICT:__________

I AM PERSONALLY ACQUAINTED WITH THE FOLLOWING LEGISLATORS: (Please list only those legislators you are willing to phone, write or personally contact.)

EXTENT OF RELATIONSHIP
(Personal friend, worked on campaign.........)

STATE REPRESENTATIVE(S):__________ - __________
__________ - __________
__________ - __________

STATE SENATOR(S):__________ - __________
__________ - __________
__________ - __________

U.S. REPRESENTATIVE(S):__________ - __________
__________ - __________
__________ - __________

OTHER GOVERNMENT OFFICIALS:__________ - __________
__________ - __________
__________ - __________

______ I would also be willing to come to Lansing in order to help MSMS Legislative efforts. PLEASE COMPLETE THE FOLLOWING: Number of hours needed to reach Lansing:________
Amount of advance notice required prior to an MSMS request for you to "visit" Lansing:______

Please check those areas in which you have a personal and/or professional interest, which you feel you would be most effective in discussing with a legislator, or could present as testimony to a committee of the legislature.

HMOs-IPAs________
NURSING HOMES________
EMERGENCY MEDICAL SERVICES________
HOME HEALTH CARE________
HOSPICES________
HEALTH PLANNING________
PHYSICIAN REIMBURSEMENT________
CONTROLLED SUBSTANCES________

DEATH/DYING ISSUES_____
PUBLIC HEALTH_______
MENTAL HEALTH_______
MEDICAL EDUCATION________
UTILIZATION REVIEW/QUALITY ASSURANCE______
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REGULATION-CERTIFICATE OF NEED, BED CAPACITY REDUCTIONS________
OTHER_____PLEASE SPECIFY__________________

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1981-1982

MEDICAL/DENTAL MEETINGS

BOYNE HIGHLANDS
Harbor Springs, MI

NAME AND GROUP CONTACT	ARRIVAL/ DEPARTURE	TYPE
EMERGENCIES IN MEDICINE Dr. Robert Wilson	1/10-1/15, '82	
TRI-STATE DENTAL Dr. Donald DeCenso	1/10-1/15, '82	
OHIO VETERINARY MEDICAL ASSOC. Dr. George Norris	1/24-1/29, '82	
FAMILY PRACTICE UPDATE CONFERENCE Janet Johnson	1/31-2/5, '82	
MICHIGAN OPTOMETRIC ASSOCIATION Dr. Phillip Irion	2/14-2/19, '82	
BOYNE WINTER IMAGING SEMINAR Dr. Robert Bree	2/14-2/19, '82	

BOYNE MOUNTAIN
Boyne Falls, MI

NAME AND GROUP CONTACT	ARRIVAL/ DEPARTURE	TYPE
MID-WINTER MEDICAL MEETING Dr. Michael Hughes	1/24-1/29, '82	
MICHIGAN HEART ASSOCIATION Eleanor Peterson, R.N.	1/31-2/5, '82	

BIG SKY OF MONTANA

NAME AND GROUP CONTACT	ARRIVAL/ DEPARTURE	TYPE
AMERICAN ASSOCIATION OF DENTISTS Morris Travel	1/16-1/23	National
ACADEMY OF FAMILY PHYSICIANS D.J. Breen, MD Hillsboro Clinic	1/24-1/30	National
MONTANA PHYSICAL THERAPY ASSOC. Diane C. Allen, LPT	1/22-1/24	State
BIG SKY RADIOLOGY Dr. Virgil B. Graves Dept. of Radiology Columbus Hospital	2/1-2/6	National
MONTANA ACADEMY OF OPHTHALMOLOGY Dr. Kenneth Younger	2/11-2/14	Regional
MONTANA ACADEMY OF DERMATOLOGY Dr. Ronald Orman	1/12-2/15	Regional
CARDIOLOGY SEMINAR Dr. Sidney Goldstein Head-Division of Cardiovascular Medicine Henry Ford Hospital	2/13-2/20	National
TRI-STATE DENTAL/ MEDICAL Hugh Henning, DDS	2/20-2/27	Regional
TOPICS IN INTERNAL MEDICINE Frances Burt	2/23-2/28	National
ANESTHESIOLOGY SEMINAR Mrs. Phyllis Sherburne Director of Educational Services Columbus Hospital	2/24-2/28	National
OB/GYN SOCIETY Dr. John Browne	3/3-3/7	Regional
BIG SKY UROLOGICAL SOCIETY Dr. Robert Towers	3/4-3/7	National
WESTERN ORTHOPEDIC ASSOCIATION James F. Schwarten, MD The Billings Clinic	3/5-3/7	Regional
CONTINUING EDUCATION SEMINAR, MEDICAL COLLEGE OF GEORGIA Morris Travel	3/7-3/13	National
MONTANA SOCIETY OF DENTISTRY FOR CHILDREN Dr. Thomas Wickliffe	3/18-3/21	State
PULMONARY DISEASES COURSE Terrie vanAllen Extended Programs in Medical Education	3/20-3/27	National
"ACHA Hospital Liability and the Quality of Patient Care" Eugenia Shuller Am. College of Hospital Administrators	1/16-1/23, '82	National
AMERICAN LUNG ASSN. OF MONTANA Earl Thomas	1/28-1/31 '82	State

For specific information regarding meeting programs and speakers, call Mitzi Kehn at Big Sky of Montana (800-548-4486) or Donna Prested at Boyne Mountain (616) 549-2441, collect.

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Wayne County Medical Society
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Detroit, MI 48207

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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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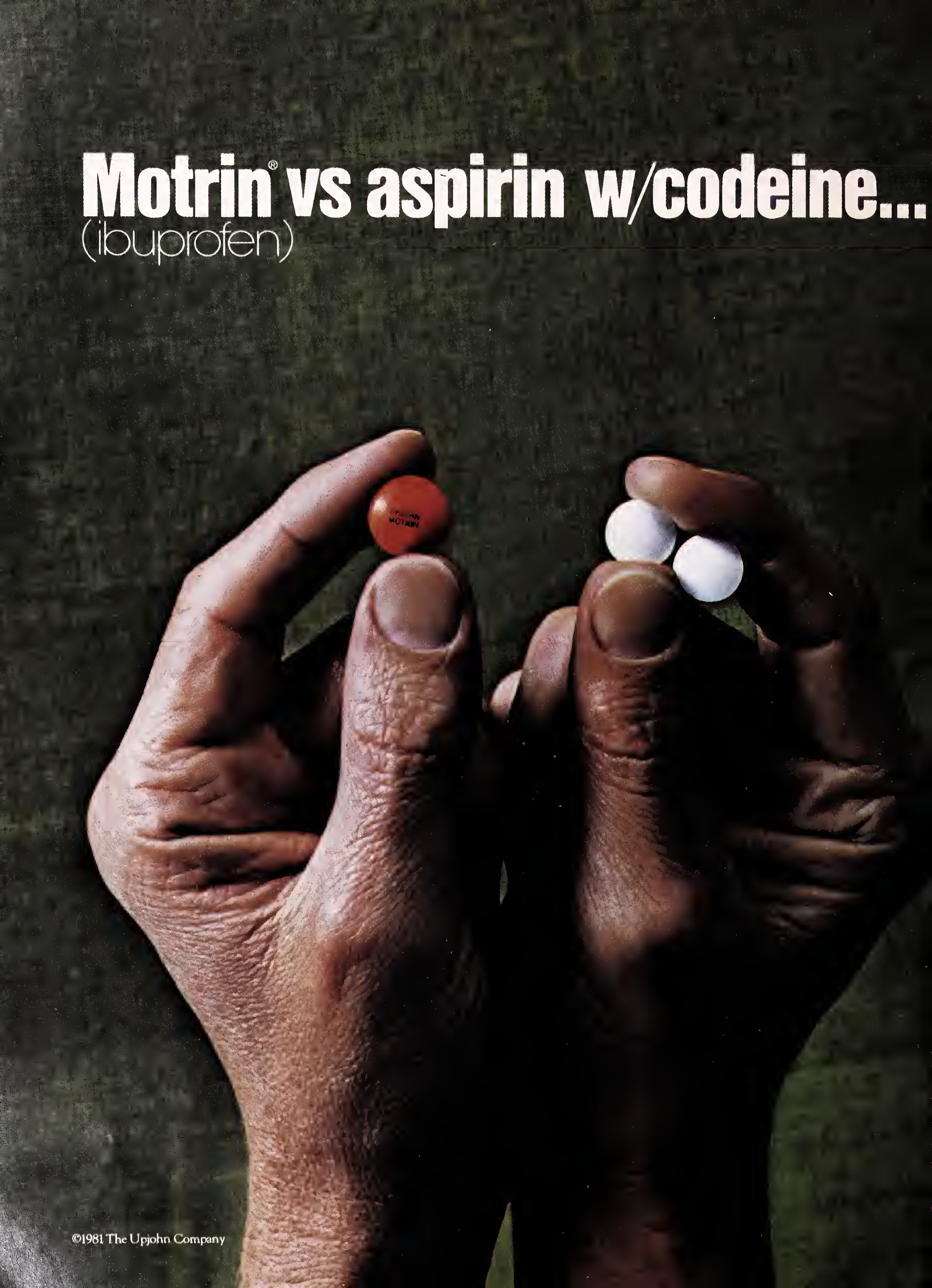
Motrin® vs aspirin w/codeine...
(ibuprofen)
MOTRIN

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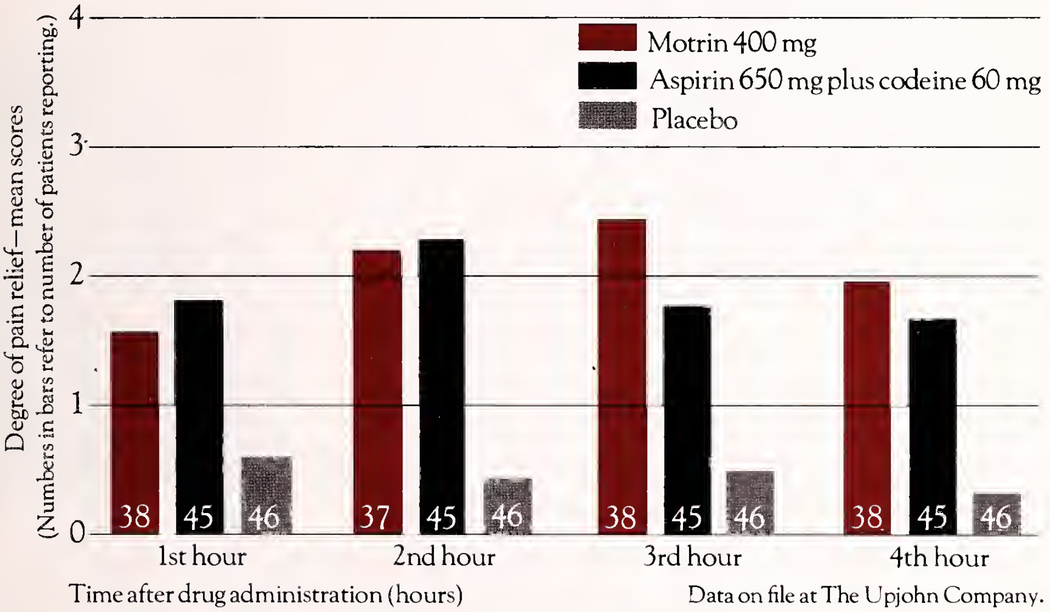
compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.



Comparison of pain relief
Motrin vs aspirin-codeine combination

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief

Data on file at The Upjohn Company.

One tablet q4-6h prn
For relief of mild to moderate pain:

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ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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Sen. Kammer's forte is finances as he makes gubernatorial bid

By Willah Weddon
Stockbridge

Sen. *Kammer*

This article is the first in a new series for *Michigan Medicine* on 1982 state gubernatorial candidates.

"If Michigan's economy continues to be devasted in 1982, the impact to all services the government provides will be even more than at present," State Senator Kerry Kammer pointed out during an interview with *Michigan Medicine*.

"I am sure Medicaid and social services, generally, will feel a major portion of those cuts," he stated frankly.

"If we go through a property tax reduction proposal of one-quarter billion dollars and revenues have been reduced by the same amount, plus the reduction of federal dollars coming into the state . . . there is no way we can do this without impacting services and education, too."

With such a gloomy prediction, why does the 33-year old Senator, who represents parts of Livingston and Oakland Counties (17th District), want to run for the governorship in 1982?

"I'm not as pessimistic as some. I think our economy will rebound. It will be more gradual, but the rebound is certain and we'll experience real growth," he countered.

He also believes it will take some exceptional management to keep Michigan fiscally afloat, as well as to provide an array of necessary services. The implication is, of course, that Kammer can do it. Based on his record in the legislature, he has some influential believers.

When he was appointed to the Senate Appropriations committee while still a freshman senator, Kammer's major interest was in educational finance.

"But I became concerned whether or not the state was wisely and efficiently spending tax-payers' dollars," he said. "I felt we could do a better job of delivering services and of making government more cost-effective."

Kammer sponsored the Budget Stabilization Act of 1977, which limits real growth in state expenditures to two-percent a year. Any excess tax money is to be set aside in a 'rainy-day' fund. Unfortunately, since the plan went into effect the state's economy hasn't been good enough to build a sizeable surplus for the fund.

The young senator also was one of the leaders in the fight for tough spending controls on mailings, printing and office redecoration costs by his colleagues. While this did not endear him to all of them, it pleased his constituents and attracted statewide attention.

Powerful committee

Today he's a member of the powerful Joint Capital Outlay subcommittee, thus taking part in the making and reviewing of state building and construction decisions.

Another accomplishment Kammer points to with satisfaction is the establishment of the Kammer Recreational Land Acquisition Trust Fund which was subsequently named in his honor by his peers. This fund was set up to utilize royalties from oil and gas drilling on state-owned lands to pay for the preservation of environmentally and recreationally critical properties.

Kammer's interest in fiscal matters does not stem from a background devoted to business administration. He was raised in Pontiac, surrounded by a family that liked to talk politics. He entered Wayne State University and obtained his Bachelor of Arts degree with an English major. During these years he also worked almost full-time for an insurance company and was active in a student political

Ms. Weddon is a free-lance writer.

KAMMER/Continued

organization that supported several Democrat candidates.

At the age of 22, Kammer served as campaign manager for the late Michigan AFL-CIO president, August Scholle, in his 1970 bid for a congressional seat. Kammer then became a regional supervisor for a life insurance company and, on the side, made an unsuccessful try for a seat in the State House of Representatives against Mel Larsen in 1972. (Larsen is presently chairman of the State Republican Central Committee.)

Elected unopposed

The next year Kammer was hired as Pontiac city clerk and left that post when he defeated a Republican incumbent (Harvey Lodge) for the State Senate post. Four years later he ran unopposed and was re-elected in the previously Republican stronghold.

Throughout his campaigns Kammer consistently decried the property tax method of financing education and promoted a graduated income tax to provide equal education for all Michigan children.

Once elected, the politically attuned senator was quick to realize power lay in the hands of the appropriations committee. As a five-year member of that committee, he now serves as chairman of three subcommittees: School Aid, Department of Education and Natural Resources.

During the years he's been dealing with state finances, Kammer has become adroit in asking questions. He'd like to know for instance, why Michigan's welfare benefits are 24 percent higher than the average for the other Great Lake States. Are recipients legitimate or not? Do they have other income? And, he suggests, "It may be necessary that we take some arbitrary action in making some changes in the Department of Social Services' budget."

He is also adamant about the need for some significant changes in law to improve Michigan's business climate, to keep businesses here and to attract new ones. Pointing out that this state has worker's compensation rates that are as much as 15 times higher than neighboring states, Kammer stresses the need to limit disability claims, and bring down premiums business must pay.

Concessions ahead

One of seven state senators who voted against the single business tax law, he says this has to be changed too. "The employer of 3 to 100 people has borne this burden," he continues.

"Labor has to understand that business has to do well for them to do well. I don't know how labor can succeed when we've driven every last job out of this state.

"Both big business and big labor are going to have to make some concessions in order to revitalize this state's economy. Otherwise, we're going to see this down-turn prolonged for more than most of us can endure."

Kammer's primary interest in public health lies in environmental issues. He served as the chairman of the special commmittee to investigate pollution and toxic substances. There are 500 potential trouble sites (toxic substances) identified by the Department of Natural Resources, he worries, but no mechanism to determine whether or not they pose a threat to the public health.

"The state's environmental protection division is fragmented." he said. "It's often difficult to determine whether a problem falls under the jurisdiction of the Department of Agriculture, Natural Resources or Public Health." And he'd like their roles defined.

Kammer has time to think about these and other matters as he makes the round trip daily, when the senate's in session, to Lansing. He and his wife, Carole, have three young children and live in Springfield Township, near Pontiac.

One of the "other matters" was whether or not to make a bid for the Democrat nomination as state governor. It means he won't be able to seek re-election as a senator and after next June the decision will be irrevocable. At this point, however, he is firmly convinced it is the right move.

Reye's Syndrome Update

The Annual Reye's Syndrome Update of the Michigan Department of Public Health reports 27 cases of Reye's Syndrome in residents of 16 Michigan counties between Sept. 1, 1980 and Sept. 30, 1981. Thirteen of the 27 cases had onset of Reye's Syndrome in January or February. Seven of the cases had a chickenpox prodrome. The cases range in age from seven months to 17 years, and sixteen of the cases were between two and seven years of age.

Only four children were admitted to a hospital at stage III or greater. Six children reached stage III or greater during their hospitalization. Only five children progressed in stage after admission and none progressed more than one stage. There were no deaths.

This annual summary includes data from a 13-month period. The MDPH has decided to change to an Oct. 1 — Sept. 30 "Reye's Syndrome year" because Oct. 1 marks, approximately, the end of the enterovirus season and the onset of the respiratory virus season.

Data for this "Reye's Syndrome year" are being collected. To date, three cases of Reye's Syndrome, including one fatal case, have been reported in October.

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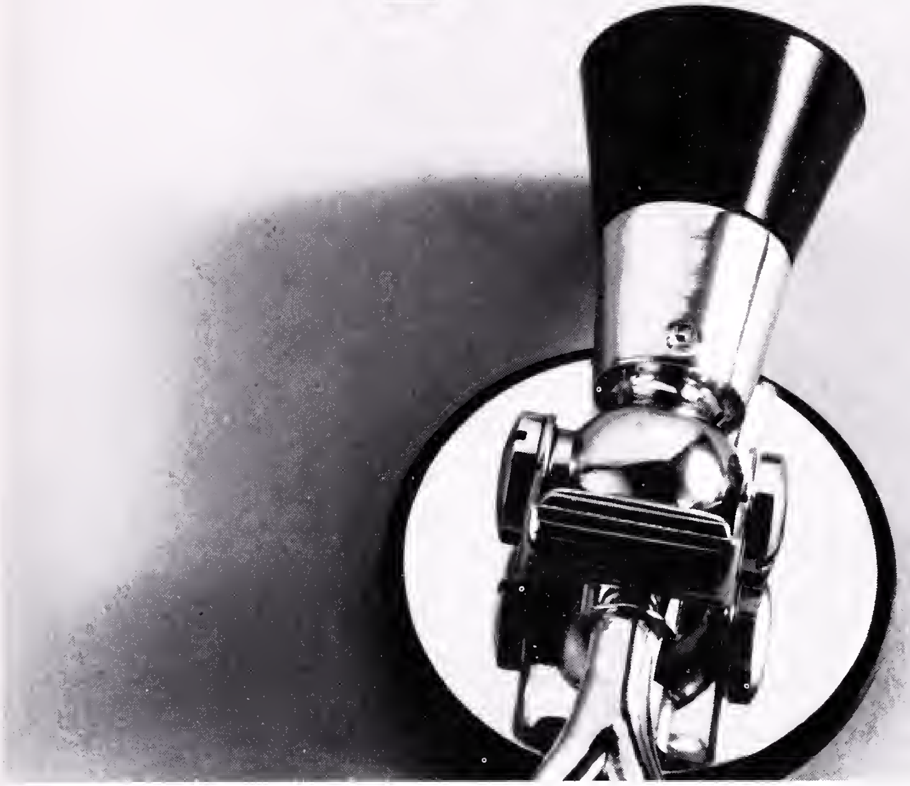

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MSMS public service campaign to help medicine, public relate

By Elmer White
Okemos

MSMS leadership, sparked by the MSMS Committee on Public Service, holds the strong conviction that both the public and the medical profession would benefit by better understanding of each other.

That conviction has sparked a public service program by MSMS to improve that understanding.

First of a series of MSMS brochures for the public was circulated in December. Others will follow during 1982 as this program gets underway.

The first brochure, "If Illness or Injury Strikes While You are Away from Home," is designed for use by travelers. It supplies basic first aid information, together with ideas about locating a doctor, once it is decided that one is needed.

The brochure, in a format which fits in the glove box of a car, provides space for each patient to list the name and telephone number of their doctor as well as information about members of the family who might need special medical attention. This includes allergies, drug patterns and other basic facts.

Sample copies of the brochure were mailed to MSMS members earlier this month, with the suggestion that a supply be ordered for dissemination to their patients. MSMS is making these brochures available for $32.50 for a package of 500, postpaid. Other copies of "If Illness Strikes" will be available to the public at highway reststops and convention centers.

Mr. White is a public relations consultant to MSMS.

If illness or injury strikes while you are away from home

What you should know if you or a member of your party has physical difficulty while vacationing or on a trip.

This information is supplied by the Michigan State Medical Society.

You can help by writing the name and phone number of your doctor in the box below.

This can help get important information quickly in case a medical history is needed.

Keep This Folder in the Glovebox of Your Car.

"If Illness or Injury Strikes While You are Away from Home," a brochure prepared by MSMS to help travelers and vacationers deal with health problems, was released this month to MSMS members.

In addition to first aid information and suggestions about securing medical help as needed, the brochure includes space for each patient to write in the name of his/her doctor with the doctor's telephone number.

Copies will also be circulated as a public service from highway reststops and other points where people might gather.

MSMS will release a brochure in 1982 describing the length of time and the details of study required of a doctor before he/she is eligible to practice. It is intended to stress the difference in training between medical doctors and other health providers, some of whom are advertising their services to the public.

MSMS has prepared an experimental brochure which now is being evaluated. It is designed to help patients understand individual doctors' office practices. Topics include how to make appointments, how to contact the doctor in an emergency, diagnosis by telephone, how lab tests are scheduled, consultation with specialists, importance of following instructions when taking prescriptions, payment for service.

Later in 1982, recommendations and samples of more brochures to explain physicians' policies and responsibilities will be released.

These projects are underway following the Public Service Committee's careful review of an MSMS-sponsored study about patient attitudes on health matters. This research was the first of its kind in Michigan to weigh consumer attitudes and doctor beliefs about consumer attitudes.

Among other findings, the study discovered that the public does not have an appreciation for the investment in time, study and finance, made by a medical doctor before he or she can be licensed to practice and

Continued on page 26

FINANCIAL INFORMATION

NAME____________________HOME PHONE____________OFFICE PHONE____________

DESCRIPTION		SELF	JOINT	SPOUSE
REAL ESTATE	RESIDENCE	$	$	$
	OTHER			
LIFE INS.	GROUP			
	PERSONAL			
EMPLOYEE BENEFITS	PENSION			
	PROFIT SHARING			
	OTHER			
STOCKS	MARKETABLE			
	CLOSELY HELD			
BANK ACCOUNTS				
BONDS				
PARTNERSHIPS				
PROPRIETORSHIPS				
TANGIBLE PERSONAL PROPERTY	FURNISHINGS			
	AUTOS, ETC.			
SUBTRACT ALL LIABILITIES				
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As the delivery of medical service to the public becomes more complicated by numerous health providers offering various sorts of services, the MSMS Public Service Committee concluded that it is important for people to understand the background of training and experience these various health providers offer to the patient.

Members of the Public Service Committee are:

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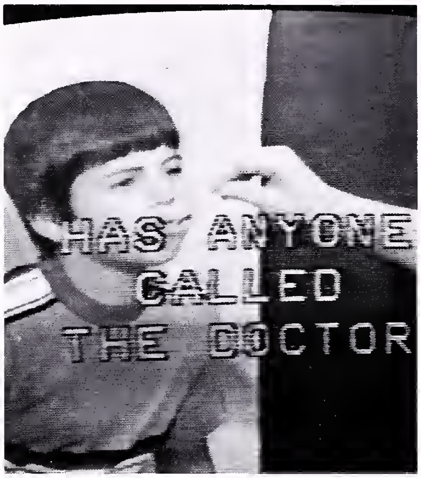
Norman Anderson, Advisor, Flint
Mrs. S. A. Yannitelli, Advisor, Battle Creek
Merwyn G. Scholten, Staff Assistant

"Has Anyone Called the Doctor?" is a 24 minute videotape which suggests nine ways patients can benefit from their relationships with doctors and from important health information.

The presentation explains why office consultation is greatly superior to the outmoded house call and the value of testing procedures in doctors' offices or hospitals. It also describes the lengthy and detailed training required of medical doctors before they are eligible to practice.

As the television schedule for the entire state is arranged, doctors in each area will be advised of details.



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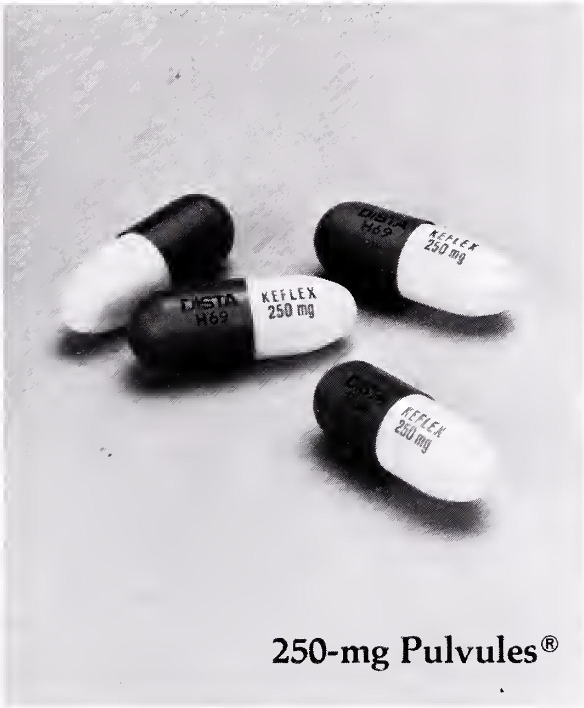

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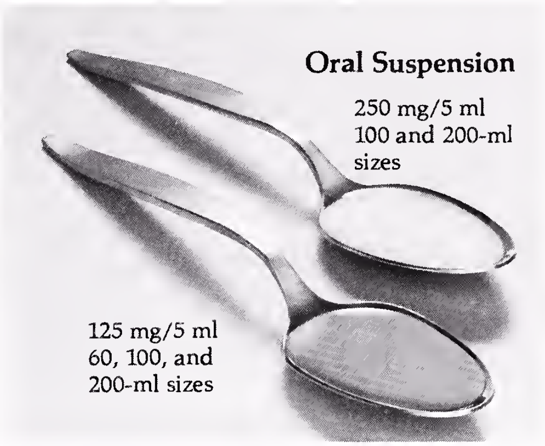

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HB 4867: The laboratory referrals bill

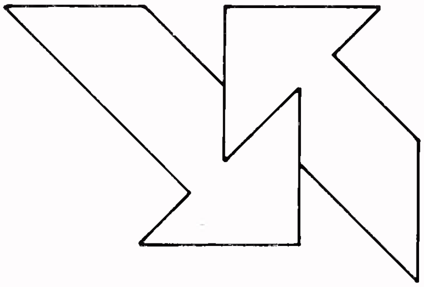
By Dwight E. M. Angell
Troy

The issue

One of the most complex and difficult health care bills before the state legislature is the issue of whether or not to prohibit physicians from sending patients or specimens to a laboratory in which the physician has a financial interest. The issue, which presently is in both the state legislature as well as the courts, has yet to come to a final resolution despite years of policy papers, task forces, legislative debate, and various legal opinions.

The major provisions of the current bill on this issue (HB 4867), as passed by the House in November, say that physicians and lab owners must disclose all financial ownership to third party payors in the next year. This will allow for "tracking" of referral and volume patterns. Referrals by a physician to a lab in which he/she has an interest can continue.

The bill also attempts to define the phrase "financial interest," which has been the source of considerable debate. The bill now allows ownership of (1) Securities issued by a publicly-held corporation; (2) A licensee's own medical practice; (3) A health maintenance organization; (4) Interest in real property resulting in a landlord-tenant relationship between a referring licensee and a person from whom the licensee orders a medical service or supply or (5) An interest in a hospital or facility in which the hospital has a majority ownership interest and is the licensee's sole financial interest.



Background

In 1977, the state attorney general rendered an opinion concluding that there was no legislative statute that prohibited physician ownership of labs to which a physician could refer patients and/or specimens. Since that opinion such arrangements apparently have flourished. For example, it was reported that Michigan Blue Cross-Blue Shield paid $15 million in 1978 for lab tests in which the physician had lab ownership. In contrast, in 1977 the Blues paid only $5 million for such tests. The attorney general's opinion prompted a legislative provision to be inserted in the new Public Health Code, passed in 1978, prohibiting such arrangements between physicians and labs.

The law reads in part that it is illegal for a physician to promote "for personal gain of an unnecessary drug, device, treatment, procedure, or service, or directing or requiring an individual to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee has a financial interest."

Soon afterwards the state's Board of Medicine asked the attorney general for an opinion clarifying several passages of the law. The opinion released in 1979 reaffirmed the Code's original prohibition.

But in the opinion of various experts, both the law and the attorney general's opinion were vague, ambiguous, and too broad, leading to possible conclusions that the law would prohibit physicians from even practicing in a health maintenance organization.

In addition, a successful injunction against the implementation of the law was granted by both a local circuit court and the Court of Appeals.

Two years ago a bill was introduced in the Senate that would have required disclosure of lab ownership if a physician had over a five percent interest. The bill died in committee.

This June HB 4867 was introduced in the House by Representative Raymond Hood (D-Detroit) in an attempt to clarify the situation once and for all.

Mr. Angell is a Detroit-area freelance writer. He will be preparing this feature for *Michigan Medicine* over the coming months.

For prohibition

The original assumption behind the 1978 prohibition in the Public Health Code was simply that physician ownership in a lab encourages overutilization because of the financial incentive for the physician. The Michigan State Medical Society "concedes that this may be occurring."

But it wasn't until this summer that advocates for a strong bill had figures to substantiate their position. That evidence was a study conducted by the Medical Services Administration (Medicaid) of the Michigan Department of Social Services.

The report tracked for six months the physician-lab referral patterns for six labs, five physician-owned and one independent. In addition, the five physician-owned labs also were used by some physicians who didn't have a financial interest in the lab.

The report concluded that "physician owners accounted for over 90 percent of the total Medicaid payments made for referral testing to the laboratories in which they had ownership interest. Further, the recipients referred by physician owners each had 27 to 240 percent more tests as those referred by non-owners."

The report also concluded that physicians with lab ownership saw an average of 254 percent more Medicaid recipients in their offices as did non-owners, and the owners referred an average of 75 percent more recipients for testing than did non-owners.

The American Clinical Laboratory Association, which endorses legislation prohibiting lab ownership by physicians to which they make referrals claim that such arrangements lead to:

- "Creation of a captive market of doctors who cease ordering tests on the basis of price, quality and service; and, instead, automatically order tests from the laboratory in which they have an investment interest.
- "Breach of the doctors' ethical duty to order laboratory tests only when needed for the health of the patients and to select a laboratory on the basis of quality, price and service.
- "Over-utilization and over-ordering of tests by doctor-investors seeking to increase the return on their investment and skirt the prohibitions of the anti-kickback and rebate law.
- "Injury to third-party payors and patients who must pay higher prices than necessary and are charged for tests that may not be medically indicated."

Against prohibition

Individuals and groups oppose any bill that would prohibit referrals by physicians with lab ownership for a variety of reasons.

For example, there is little evidence that such financial arrangements promote abuse and overutilization as pervasive as has been alleged. Steve Crane, assistant professor at the School of Public Health at the University of Michigan points out that the lab study by the Medical Services Administration is not sound, under close scrutiny.

"I do not believe that the connection between ownership and lab test utilization is necessarily demonstrated by the data presented in the study.

"Indeed, based on this study, it is not even possible to determine whether the differences are in fact statistically significant."

The Michigan State Medical Society believes that physician ownership is ethical, "provided the patient is not exploited."

MSMS also argues that prohibition is unnecessary simply because there isn't enough data to prove abuse takes place. (There is no data as to who owns labs.)

Crane points out in a major policy paper about the issue that prohibition against referrals can have negative impacts:

- Some labs, may be eliminated thereby increasing the "possibility for monopoly control of the market by large clinical companies;"
- Physicians might be forced to move the labs inside their own offices. "This approach would result in a duplication of services, further increasing total expenditures and not decreasing the volume of services utilized."
- Prices for the consumer most likely would increase for lab tests.
- Physicians whose income is dependent on lab services may make up the differences in other ways — increasing the price and number of patient visits.
- Quality of lab tests may suffer, as labs established in physicians' offices may not require licensure.

Outcome

Considering the long and complex history of the issue and the vested interest of both sides, it is difficult to predict the likely conclusion for the bill.

The version that passed the House could very well be significantly altered in the Senate. Then both chambers would need to compromise.

But should it pass in its present form, then only the results a year from now will determine the outcome. For if it is found that abuse and unnecessary utilization exist among physicians having a financial stake in a lab, one could expect a legislative prohibition of such arrangements.

On the other hand, if such abuse is not a major problem, a legislative prohibition likely will die.

1981 MSMS Annual Scientific Meeting best ever

The second largest number of physicians ever – 1,500 – attended the MSMS Annual Scientific Meeting Nov. 17-19 at the Hyatt Regency Dearborn. They came to earn CME credit offered through 57 half-day courses presented by MSMS, with cooperation of Michigan medical schools and most medical specialty societies. They heard faculty members from Michigan, Canada and 13 states. One of the most dynamic courses was the session on arm pain, which presented approximately 20 patients for live demonstrations and discussion.

The arm pain course was more dramatic due to the presence of technicians and equipment to videotape examinations by speaker Maury R. Ellenberg, MD, Detroit. Monitors about the room displayed the action live and up close to the physicians in the audience, making it easy for them to see what was happening.

With attendance high, the MSMS registration desk was a busy area. It also served as the message center, and was located in the exhibit hall.

Seventy-five exhibitors in the exhibit hall adjacent to the instruction areas were busy during the three-day meeting, as physicians looked over their wares and services.

1982 Annual Scientific Meeting Dates: Nov. 9-11 Hyatt Regency Dearborn

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Physician-students and faculty members queued in the exhibit hall for the daily luncheons provided by the hotel. At the end of each day, free beer was served by MSMS to promote informal sessions between speakers and attendees.

Photos by Mert Scholten, MSMS staff

New year's resolution: Encourage spouse to join active, involved MSMS Auxiliary

By Cheri Calvelo
Jackson

There is an organization that only the spouse of a physician can belong to. It extends your work as a physician into the community, where it is needed to help keep people healthy.

It is the only organization in which 80,000 people speak as one on issues that affect health care and the practice of medicine. Last year nearly $2 million was raised and donated to ensure quality education and equipment for medical students and schools. This organization is the medical auxiliary!

This country's auxiliaries are organized on national, state and county levels. It is through this federated structure that goals of protecting and improving public health, and of assisting physicians in providing quality medical care, can be realized. The federation is necessary to create the strongest possible organization for sharing from all levels.

National

The national organization serves as an umbrella for activities. It provides coordination of programs to serve the medical profession. It distributes information on fund raising, health projects, legislation, membership, bylaws, and parliamentary procedure. It provides program materials, including packages on 10 health topics, and the Project Bank, a national clearinghouse that holds 850 local auxiliary projects.

An organization can only be strong if the leadership is effectively prepared, through information and training. If an individual county or state has a particular concern, field service is provided from national officers and chairmen. There are publications for every member; some designed specifically for leaders, and one specifically for resident physicians' and medical students' spouses.

State

The Michigan State Medical Society Auxiliary serves as the coordinating body between national and county levels. Leaders share their training and experience with others to support leadership development. There are statewide programs which bring health care to communities, along with assistance and direction for county programs.

When a need for legislative action on a specific issue arises, there is a network of volunteers to pass along appropriate information. One day is set aside each year for a legislative update. The MSMS Auxiliary actively participates in raising funds for AMA-ERF. The *Auxilium* is the state newsletter, which is sent to each member who pays dues. The state organization enables each auxiliary to be as effective as possible through communication and implementation.

County

The county auxiliary is the catalyst for community health activities, and provides positive public relations for the medical profession. It can be the liaison to community organizations such as hospital auxiliaries, cancer societies, and other volunteer health organizations to increase cooperative efforts and decrease duplication of services. Manpower to respond to legislative issues can be found in the county auxiliaries.

The AMA Auxiliary has had one basic purpose since 1922 — to serve individual communities by assuring quality health and health care for its people. This can only be accomplished through county auxiliaries.

Every member may not be able to be actively involved every year, as our lives pass through different phases and we have different needs at different times. However, auxiliary dues can be a part of a strong voice that can provide positive public relations and support for the medical profession.

By paying national dues of $11, state dues of $5, and county dues assessments, your spouse is eligible for membership in all three.

Remember only the spouse of a physician can belong! If your spouse is not a member of the federation of auxiliaries, encourage her or him to join.

You might consider giving your spouse a gift of membership.

Mrs. Calvelo is president-elect of the MSMS Auxiliary.

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Auxiliary's Medicare seminars provide needed information

A major new community service project of the MSMS Auxiliary is a series of workshops to help the state's citizens better understand the Medicare system. The Auxiliary is working with the Michigan Hospital Association Auxiliary and Blue Cross Blue Shield of Michigan in this effort. At the kick-off seminar in Grand Rapids, medical assistant Joan Conrad fielded a number of questions from members of the audience.

Barbara Grennan, Muskegon, current MSMS/A president, discussed Medicare recipients' problems with Sen. Mitch Irwin, who made an appearance during the program. Presentations helped recipients learn about the Medicare structure, policy and recent benefits payment changes; and about how to fill out claims forms. The MSMS Auxiliary and its cosponsors hope to repeat the seminars in cities across the state.

Auxiliary endorsing Donor Week

Following the overwhelming success of the Washington State Medical Association Auxiliary's First Annual Organ Donor Week in April, 1981, the American Medical Association Auxiliary is endorsing and assisting in the First Annual National Organ Donation Week in mid-April.

The AMA Auxiliary will work to improve public awareness and acceptance of organ donation throughout our nation during this week. The donation of an organ, whether it be kidney, liver or cornea, bone, skin or pituitary gland, suggests to both the donor and his or her loved ones the transference of life, rather than the ending of life. The concept of organ donation thus should convey a special and lasting gift of love from the donor to the recipient. We, in Michigan, have the Uniform Anatomical Gift Act. With each driver's license and renewal comes the green organ donor information brochure and a donor sticker to be attached to the back of one's driver's license. Whether specific anatomical gifts for transplants are designated or the whole body donation program is chosen, signing the donor card in the presence of two witnesses, indicating one's choice of organ or body donation on it, and notifying one's family and physician of such intent are the three important steps in becoming a participant in the donor program.

The National Institute for Burn Medicine, (313) 769-9000 in Ann Arbor and the Michigan Eye Bank at WSU (313) 577-1329 and at the U of M are state organizations directly involved in transplants.

The Kidney Foundation of Michigan, 1-800-482-1455, and the Transplantation Society, 1-800-482-4881, provide information and referral service throughout the state on a 24 hour basis.

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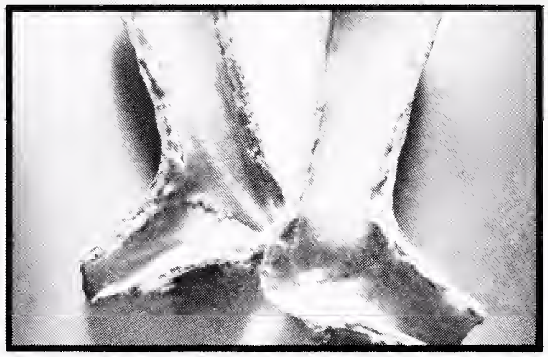

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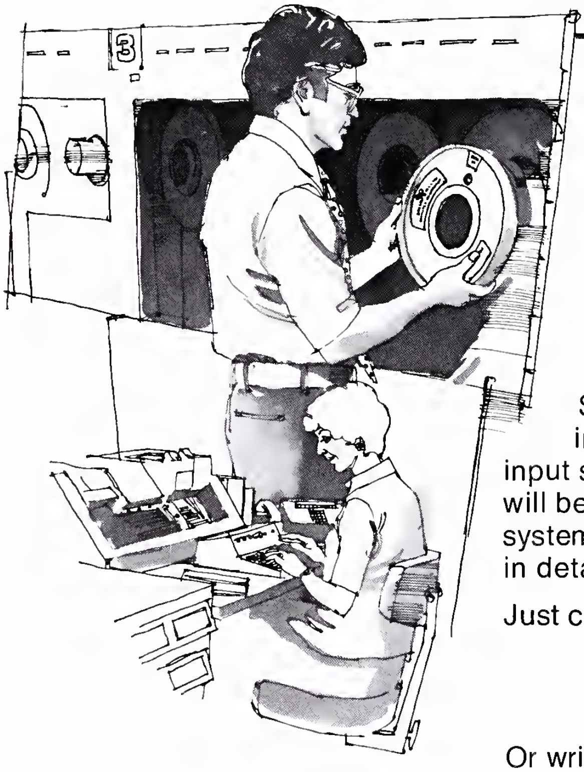

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Stay with Zaroxolyn because it maintains effectiveness in long-term therapy[1,5,6]. . . and minimizes the need for Step-2 agents.

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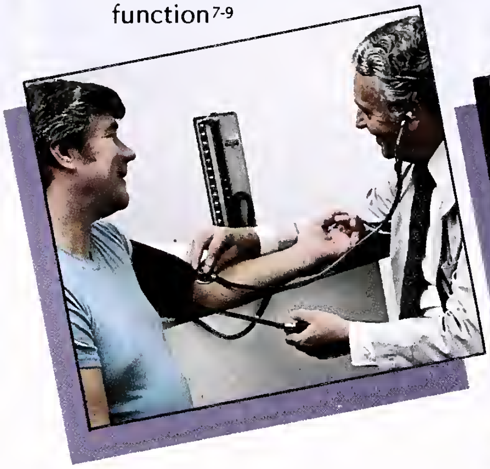

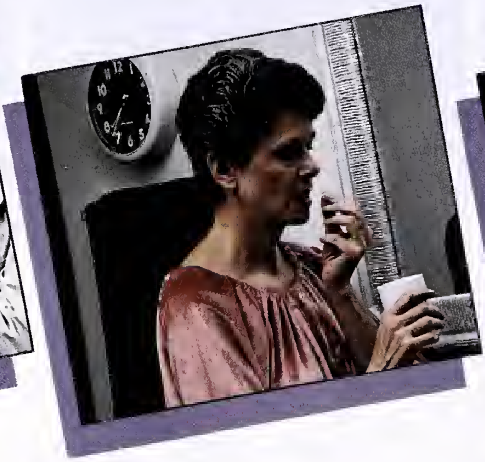

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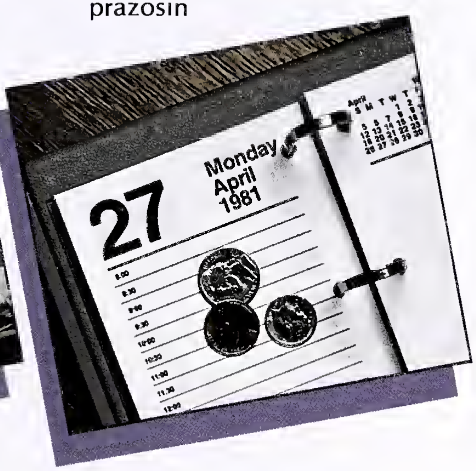

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References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York, Stratton, 1976, pp 221-245. 3. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 4. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 5. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 7. Puschett JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 8. Craswell PW, Ezzat E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 9. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 10. *Drug Topics Red Book 1981*, and manufacturers' suggested prices.

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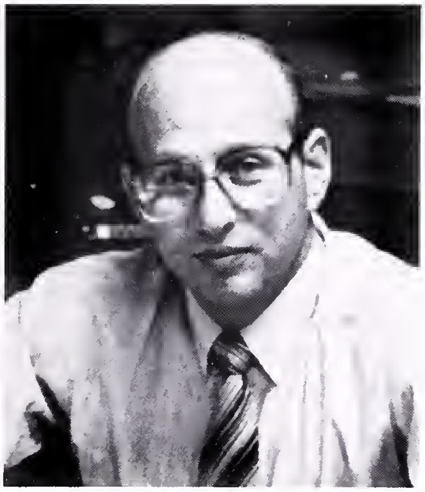
A-297

New WSU med school dean wants to improve residencies, research

By Shelton Reece
Detroit



Dean Nadler

"Wayne State University's School of Medicine is like a hidden jewel," according to its new, young Dean; Henry L. Nadler, MD. And it's much better than its reputation."

Doctor Nadler, who became dean on Sept. 1, said he hopes to improve the overall quality of the school's residency programs, as well as the quality and amount of first-rate research program.

"Let me emphasize that residency programs here are, in a large part, very good. Indeed, they are much better than their reputations. Also, there are some truly excellent research programs, and we will develop more.

"This medical school trains future physicians exceptionally well," he continued. "A large percentage of them stay in Michigan to practice, so the institution certainly fulfills its obligation to the State."

"It also is an extremely important element in the delivery of health care to the people of Detroit. So far as I know, Detroit is the largest city in the country served by only one medical school. Therefore, our faculty members are key physicians in the Detroit Medical Center, and in many other hospitals in the area."

Another of Doctor Nadler's goals is to increase the clinical faculty while "fine-tuning the basic sciences."

"The ratio of clinical faculty members is still quite low when compared to the numbers of students, residents, and patients with whom they must work," he says. He attributes this deficit to the push during the past decade to enlarge the size of medical school classes. Clinical faculties lagged during the push, he says.

"In the next few years we, at WSU Medical School, are going to do something constructive about this situation. Somehow, we are going to find the resources to strengthen our clinical faculty."

Doctor Nadler acknowledges that most institutions are feeling the effects of the sluggish economy. However, he said he doubts that funding from the State will continue to be decreased.

"It's not realistic to expect additional funds from state government soon. But if we are to train physicians, neither is it realistic to expect funds to be cut again. Should further cuts come, we surely would have to discontinue entire programs.

Concerning funding, Doctor Nadler said he also feels that the private sector must increase medical school support. He says this has occurred, to a certain extent, at the Detroit school.

"I have been encouraged by the number of research grants this school has received lately. Although the competition has increased greatly, WSU Medical School has bucked the trend and obtained more grants in the last few years than ever before.

"While we were one of the last medical schools in the nation to develop a faculty practice plan, our faculty now is becoming more and more active in treating patients. This, of course, will not only augment our finances, but also will provide more health care to more patients in the area."

Income from faculty practice is important at WSU Medical School for some basic reasons, Doctor Nadler stresses. These include enabling the school to attract and retain quality faculty members by paying them salaries comparable to those of physicians in other medical centers; and providing additional funds to departments and to the Dean's Fund, for educational research.

"Since there is no money available from the University, nor from grants, for purchasing medical research equipment, the Dean's Fund is very important. That fund receives a certain percentage of the income realized from faculty practice. With those monies, it can buy the equipment that is necessary for modern research."

Another of Doctor Nadler's immediate plans is to take a close look at how resources within the school are deployed. He plans to ascertain if there is enough support given departments to enable them to meet their primary missions, and if they are, indeed, meeting their objectives.

"As I view it, the Department of Medicine is the flagship of a medical school. One of my aims is to strengthen our department here. It is seriously understaffed, and yet it manages to give excellent patient care. However, we do need to upgrade its scholarly productivity."

Perhaps the most pressing need of WSU Medical School and the De-

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Mr. Reece is a freelance writer.

DEAN NADLER/Continued

troit Medical Center, in Doctor Nadler's view is stability of support.

"The Medical School and Detroit Medical Center could be excellent if there were enough stability," he says. "They are good now, but still they do lack an overall excellence that can hardly be achieved, much less maintained, in a climate of gearing up for a time, and then cutting back for awhile."

He sees such stability coming from the University, private, and other usual avenues of support, but only if commitments are kept for long periods of time.

But the need for support is not a one-way proposition, according to the dean. Medical schools should support practicing physicians, he believes.

"We both need each other," he says. ". . . and what better way for medical schools to be supportive of physicians practicing in the field than to offer innovative approaches to continuing education?

"I consider many lectureships in continuing education almost wastes of time," he continues. "I would like for WSU Medical School to develop a program where physicians could really get involved in continuing their education. Perhaps we could send someone well qualified to physicians' offices to cover their practices while they come here, work/study awhile and actively continue their education."

He recognizes the necessity for a close, effective relationship between practicing physicians and the school. "I hope that we, at WSU Medical School, can somehow manage not only to maintain, but to improve, our relationships with private physicians throughout this area," he says.

Doctor Nadler earned his MD, 1961, at Northwestern University Medical School, and an MS in medical genetics at the University of Wisconsin, 1965.

A native of New York City, the 45-year-old physician completed an internship in pediatrics at New York University Medical Center, 1961-62; was a Senior Resident there in 1962-63; Chief Resident, 1963-64, and practiced, under a pediatric research fellowship, at Children's Memorial Hospital, Northwestern University, 1964-65. He has been a clinical instructor in pediatrics at New York University School of Medicine and the University of Wisconsin School of Medicine. At Northwestern's School of Medicine, he began as an associate in pediatrics, 1965, and was named chairman, Department of Pediatrics, in 1970. He held the chairmanship until he came to WSU.

Doctor Nadler is certified by the National Board of Medical Examiners and the American Board of Pediatrics. He was served as Head, Division of Genetics, Children's Memorial Hospital (1968-1981); Chief of Staff there, 1970-1981; Visiting Staff, Division of Medicine, Northwestern Memorial Hospital, 1971-1981; Affiliate Staff member, Evanston Hospital, 1974-1981, and Consultant at Cook County Hospital, Chicago.

He was named a Fellow in the American Academy of Pediatrics, 1967, and is a member of: American Society for Clinical Investigation, American Society of Human Genetics, American Pediatric Society, Society of Pediatric Research, Midwest Society for Pediatric Research, Pan American Medical Association, Society for Experimental Biology and Medicine, and the Society for Inherited Metabolic Diseases.

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AMA jail health project continues under reduced funding

The American Medical Association's Program to Improve Medical Care and Health Services in Correctional Institutions will receive funding from the Robert Wood Johnson Foundation to continue its work in jail health accreditation.

Further accreditation activities will be performed by an outside organization under contract with the AMA's Education and Research Foundation.

The funding for the program, encompassing a two-year period from November 1, 1981 to October 31, 1983, will total $398,258. This amount is less than previous funding but is sufficient to maintain a central office operation to work with state medical societies involved in the program.

The AMA reports that seven state medical associations have secured funding to continue their projects on a full-time basis and ten more plan to continue part-time, making on-site assistance available in some areas.

The program, operating since July 1, 1975, was formerly funded primarily by the Law Enforcement Assistance Administration (LEAA) with additional monies from the AMA and participating state societies.

Funnybones

Patient: "How soon will I know anything after I come out of the anesthetic?"

Physician: "Well, that's expecting a lot from the anesthetic."

Are the results of $100 million worth of government-funded research on hypertension worth reading about?

Stress what you make of it, learn MSMS Health Issue Conference-goers

By Kim Dean
East Lansing

How it felt to be a female medical student and surgeon-in-training was the topic of Susan Adelman, MD, during the MSMS conference on "Stress and the Contemporary Woman."

LONG'S OF LANSING

With a repertoire of accents from Yiddish to Finnish, and a presentation full of wry observations on contemporary life, keynote speaker Robert S. Eliot, MD, kept his audience in grins. That included Conference Chairman Marguerite Shearer, MD, Dexter.

"Stress may be the spice of life or the kiss of death," concluded Robert S. Eliot, M.D., during the Michigan State Medical Society's Nov. 4 conference on "Stress and the Contemporary Woman."

The conference was designed to allow physicians, nurses and other health professionals the opportunity to gain new knowledge of scientific data related to the identification and management of stress. In keynoting the day long conference, Doctor Eliot, professor of medicine and chairman of the Department of Preventive and Stress Medicine at the University of Nebraska, emphasized ways to be productive without being self-destructive.

In his lecture on managing 20th century stress, he stated that stress is merely the mismatch of what individuals expect and what the environment provides. "In fact," he said, "it is okay to be what is okay with you."

Through lectures on critical decision points in life, Kathleen McAuliffe, MD, Lansing and F. Paul Pearsall, MD, Detroit examined and identified critical areas in the life cycles of women. Doctor Pearsall, chief of the Problems of Daily Living Clinic in Sinai Hospital of Detroit, further noted 13 stages which professional women go through. He said that those who deal well with stress view those stressful situations as a challenge, with a sense of control and a sense of committment.

"In A Man's World — In A Pig's Eye," was the luncheon topic as entitled by speaker Susan E. Adelman, MD. She discussed the changing role of women in medicine, especially in surgery, through insights from her own career.

In the afternoon session Linda J. Logsdon, MD, a psychiatrist from Southfield, identified those environmental elements, both internal and external, which effect stress. She stated that while anxiety is the most blatant expression of stress, depression serves as the most common retreat. One of the greatest concerns that she has found among women is the lack of support systems they have. Women tend to steer away from support systems, she said, because of increasing levels of competition they feel with women.

Ms. Dean is a senior at Michigan State University and is a communications intern with MSMS.

Reproductive issues and sexuality were addressed by Doctors Marguerite Shearer, MD, and Marshall Shearer, MD, reknowned Ann Arbor area sex therapists and columnists. They noted that as women expand their lives, they have a great problem compromising and therefore must have their own priorities well in mind. In addition, they said women need the right to pursue power vigorously while men need the right to put relationships first.

MCAULIFFE
PEARSALL

Other contributors to the conference included, from left, Patricia Leuzzi, assistant director, Michigan Women's Commission; Kathleen McAuliffe, MD, Lansing family practitioner, and F. Paul Pearsall, PhD, chief, Problems of Daily Living Clinic, Sinai Hospital of Detroit.

Relationships, especially in marriage, were the focus of the Shearer's discussion. One of the single most important aspects to be aware of upon entering marriage, they said, are the expectations you have of each other. Second guessing your partner is a sure way to guess wrong, they said.

Through their work with couples they have found that elimination of certain words from the vocabulary can enhance communication and the relationship one has with a life partner. In their counseling sessions couples are asked to start all sentences with the word "I" and eliminate the word "why" due to its accusatory nature. "Should" and "ought" also have minimal application in a marriage, as they carry moral obligations. These words, they said, allow you to set yourself up for guilt. "The only way to coast in a relationship is downhill," they said. "Stressful situations occur when people don't represent themselves."

In 1977, when the Veterans Administration compared Step-2 regimens in 450 mild hypertensive patients, **which regimen was proven most effective?**[1]

FINANCES

Money purchase plan retirement option for younger physician

By David R. Nadeau
Grand Rapids

In the last article, we discussed the characteristics of qualified profit-sharing plans. Another type of defined contribution plan that is similar to the profit-sharing is called a money purchase plan.

As in the profit-sharing plan, each participant in a money purchase plan has an individual account established and maintained on his behalf. There are, however, several key differences between the two types of plans.

Specifically, these include the following.

- Fixed contribution rate
- No reference to corporate profits
- Treatment of forfeitures

The Plan Administrator is responsible for maintaining plan records including individual account balances, allocation of contributions and investment earnings, and government reporting forms. These records show the amount credited to each participant on an annual basis; and the account balance at retirement is used to provide retirement income.

Amount set

Contributions to a money purchase plan must be made regardless of corporate profits and the rate of contribution must be specified in the plan document. The contribution can be set at any amount up to 25 percent of each participant's compensation. However, if a corporation has two defined contribution plans in effect (i.e., a profit sharing plan and a money purchase plan) the total contribution cannot exceed 25 percent of compensation. The most common arrangement where these two plans are utilized is to have a profit sharing plan calling for a 15 percent contribution and a money purchase plan limited to 10 percent of compensation. This provides some stability of contributions but also gives an employer some flexibility if it is required.

After the contribution has been made to the plan, each participant's account must be credited with a portion of the contribution according to the allocation formula. The most common and easiest allocation formula is to apply the contribution rate to each participant's compensation. For example, if the contribution formula is 10 percent of payroll, each participant would receive 10 percent of his individual compensation. The allocation formula can be integrated with Social Security to provide a larger share of the contribution to the higher paid employees.

While this is not intended to be an in-depth discussion of the integration concept, it is important to show how this arrangement is used. Given a total payroll of $277,000 and a contribution rate of 8.9 percent, the contribution of $24,760 could be allocated as follows. (See example below) This is just one example of the many alternatives that are available in allocating a contribution to a money purchase plan.

Gains and losses

Investment gains and losses must also be allocated each year. Generally, each participant will share in the earnings based on his account balance at the beginning of the plan year. It is also acceptable, however, to use an averaging method as long as it is not discriminatory toward the lower-paid employees.

When a participant's employment is terminated, there is usually a distribution of the "vested" amount in the individual's account. The schedule of vesting must be specified in the plan document and is subject to strict Internal Revenue Service regulations. The amount of the nonvested balance is called a forfeiture and must be used to reduce future employer contribution. For example, assume the plan calls for a contribution of 10 percent compensation and forfeitures for the year amount to 1 percent of compensation. The employer can only contribute nine percent of pay and the forfeitures are added to the contribution so that a full 10 percent is allocated among the remaining participants.

IRS regulations also control the maximum amount that can be allocated to each individual's account during the year. The 1981 maximum is the lesser of $41,500, or 25 percent of compensation. For example, if an individual had compensation of $250,000 for 1981, the maximum amount that could be contributed on his behalf is $41,500 or 16.6 percent of compensation. This limitation applies to all defined contribution plans sponsored by the employer.

Continued on page 49

	Compensation	3% of Compensation	7% of Compensation in Excess of $15,000	Total Allocation
Doctor A	$250,000	$7,500	$16,450	$23,950
Employee A	15,000	450	-0-	450
Employee B	12,000	360	-0-	360

Mr. Nadeau is a senior consultant with Watkins, Ross, Baines, & Lamps Inc., an actuarial and employee benefit consulting firm with offices in Grand Rapids and Detroit.

Health Department has new rules for newborn eye prophylaxis

The following announcement was mailed Oct. 30 to local health officer/administrators, hospital administrators and physicians-in-charge, newborn nurseries. It was sent by Bailus Walker, Jr., PhD, MPH, Director, Michigan Department of Public Health. The subject is newborn eye prophylaxis.

This department has written new rules for eye prophylaxis in newborns and has secured necessary approval. The new rules make changes in order to be compatible with current medical practice. They take effect on Oct. 31.

These rules provide for alternatives to the 1 percent silver nitrate solution. These agents are 0.5 percent erythromycin and 1 percent tetracycline, either as ointment or solution. Please note that single use preparations are required to prevent transfer of infection among newborns.

Until new birth certificates are printed, please use the current box on silver nitrate whenever any of the approved prophylaxes are instilled in the eyes of each newborn.

If you have questions about this, please write or phone Thomas R. Kirk, MD, chief, Division of Child Health at the MDPH, or (517) 373-0657.

The new rule

Filed with the Secretary of State on October 15, 1981. This rule takes effect 15 days after filing with the Secretary of State

(By authority conferred on the department of public health by sections 2226(d), 2233, 5111, and 5269 of Act No. 368 of the Public Acts of 1978, as amended, and section 9 of Act No. 380 of the Public Acts of 1965, as amended, being §§333.2226(d), 333.2233, 333.5111, 333.5269, and 16.109 of the Michigan Compiled Laws)

R 325.60 of the Michigan Administrative Code, appearing on page 1721 of the 1979 Michigan Administrative Code, is amended to read as follows:

R. 325.60 Newborn eye prophylaxis.

The following prophylaxes against ophthalmia neonatorum are approved:

(a) Silver nitrate solution (1 percent) in single-dose ampules.

(b) Erythromycin (0.5 percent) ophthalmic ointment or drops in single-use tubes or ampules.

(c) Tetracycline (1 percent) ophthalmic ointment or drops in single-use tubes or ampules.

(d) Another substance for which written permission has been given by the director of the Michigan department of public health for controlled experimental use.

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), which Step-2 regimen was preferred and was deemed effective without significant adverse effects?[2]

NEWSFRONTS

The new Hepatitis B virus vaccine is both extremely safe and highly effective, according to results presented at the recent meeting of the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC).

According to a report in the Medical News section of the *Journal of the American Medical Association* (Nov. 13), this favorable outcome should spur approval of the vaccine, which is expected to become available in the spring or early summer of 1982.

A large number of men with prostate cancer that has not spread beyond the original tumor site should be receiving curative radiation therapy or surgery, but aren't, according to the American College of Surgeons and the American College of Radiology.

A report in the *Journal of the American Medical Association* (Oct. 16) states that findings from a 1979 ACS survey show that most of these patients are receiving either no treatment at all or treatments that offer relief from symptoms and slow the progress of the tumor but do not attempt a cure.

More aggressive treatments, such as radiation therapy and removal of the entire prostate gland, are not being attempted as often as they should, say spokesmen for the two specialty groups.

A clinic to treat growth, learning and behavior disorders in children has been formed at The University of Michigan Hospital.

The goal of the clinic is to identify problems, assess causes and recommend treatment, therapy and support services.

The Child Development Clinic will be staffed by Delores Garcia, MD, Herbert Grossman, MD, and Linda Bond, MSN. Consultative services in psychology, social work, education, audiology and speech pathology will be provided by the Institute for the Study of Mental Retardation and Related Disabilities (ISMRRD) staff.

The clinic will be held every Friday from 1 to 5 p.m. on the second floor of University Hospital's Outpatient Building. For further information, or referral, call ISMRRD's Clinical Services Division at (313) 763-4151.

Brain bleeding episodes in premature children have been reduced by 75 percent through a new use of an old drug, report U-M Hospital physicians.

In a controlled U-M study in which half of 60 premature infants were given phenobarbital shortly after birth, only 13.3 percent of those getting the barbiturate drug had hemorrhages as compared to 46.7 percent in the control group, according to Steven M. Donn, MD, assistant professor of pediatrics and communicable diseases at U-M and the study's principal investigator.

"There was no acute adverse reaction in any of the babies treated," Dr. Donn said. "The results are encouraging but are yet to be proven over the long term."

U-M scientists theorize the sedative drug's success may depend on its ability to control brain and physical activity and thus control blood pressure, an immediate cause of blood vessel damage.

Before the development of ultrasound and CAT x-ray scanners, which allow doctors to make frequent examinations of the infants, the incidence of brain hemorrhages in surviving premature babies was not known.

"Almost all this information was unknown four years ago," Dr. Donn said, "and a study like this one would not have been possible."

The Tecumseh Community Health Study of the U-M is recipient of two major research grants totalling $650,000.

The "Tecumseh project" is a 20-year investigation of how environmental, genetic and behavior patterns influence the development of chronic illnesses, including coronary heart disease and cancer. The study is being conducted among the population of Tecumseh, located 27 miles from the U-M campus.

Researchers associated with Victor Hawthorne, MD, chairman of the U-M epidemiology department, will study how dietary habits of the Tecumseh population have changed over time and how food choices may relate to the onset of cancer and heart disease. A $432,000 grant from the National Cancer Institute will fund the project.

In addition, Millicent Higgins, MD, also a professor in the epidemiology department, has received a $217,000 two-year grant from the National Heart, Blood and Lung Institute.

Doctor Higgins and her colleagues will analyze 20 years of blood pressure results, gathered from 9,000 Tecumseh community residents. Researchers hope to identify the predictors — and risk factors — for developing high blood pressure and to gain more information about how high blood pressure influences the development of cardiovascular disease (including coronary heart disease and strokes).

They also will investigate family resemblence in blood pressure levels, studying blood relatives and nonrelatives, including spouses living together and apart.

The experimental drug Nafazatrom stops the metastasis of cancer in laboratory animals, a team of Wayne State University researchers has found.

The WSU team hopes to begin studies on human patients in three to six months.

Their discovery is based upon findings that Nafazatrom elevates the level of prostacyclin in the body. The Wayne researchers reported in Science magazine in June that elevated levels of prostacyclin stop cancer metastasis in laboratory animals by disrupting the process by which tumor cells join to certain blood cells and travel to different parts of the body.

They propose that Nafazatrom

stimulates the protein responsible for the manufacture of prostacyclin.

Wayne State University is among several institutions which have requested permission to engage in clinical trials of Nafazatrom. Laurence Baker, MD, will be in charge of the clinical trials if they are conducted at Wayne.

A major, federally funded drug study has been concluded eight months early after analysis of data showed that a group of heart attack patients receiving the drug Inderal (generically known as propranolol) had a 26 percent lower death rate than the control group not receiving the drug.

The figure was considered significant enough to call an early end to the study and announce to the public, including the study gorup not receiving the drug, the results gathered to date.

Of the almost 4,000 heart attack patients in the nationwide study, approximately 150 were patient volunteers from Henry Ford Hospital.

The curtailment of the study was announced concurrently by the sponsoring National Heart, Lung and Blood Institute of the National Institutes of Health in Washington, DC, and by many of the 31 participating centers, including Henry Ford Hospital (HFH). HFH was the only medical center in Michigan chosen as a study site.

Data from HFH and the other study sites as of Oct. 2 showed a mortality of 9.5 percent in the placebo group (183 deaths) and of 7 percent in the propranolol group (135 deaths), a different of 26 percent. Site of the patient infarct, age and sex had no impact on the efficacy of propranolol. The NIH conservatively estimates that 6,500 lives may be saved in the United States annually by use of the drug.

A recent study, "Informing Patients About Drugs" by the Rand Corporation, prepared for the Food and Drug Administration (FDA), fails to provide conclusive evidence that a federal program mandating patient package inserts (PPIs) is justified, says the American Society of Internal Medicine (ASIM).

FINANCES/Continued

This means that the $41,500 is an aggregate limit and all plans must be combined for purposes of applying this limitation. The dollar limitation is increased annually by the IRS, based on increases in the cost of living during the preceding year.

Meeting needs

In summary, a money purchase plan will permit an individual to shelter 25 percent of his compensation up to a maximum dollar limitation of $41,500. There is no need for actuarial services and the administrative burden is relatively light. The major drawback is that 25 percent of compensation (or $41,500) may not be sufficient to provide the necessary retirement benefits. This is especially true for professionals who are older when they first establish a qualified retirement plan.

Professional advice should always be sought before establishing a retirement plan of any type. This is important not only to assure the tax-qualified status of the plan, but also to be sure that the plan will meet the retirement needs of the individuals.

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, **which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?[3]**

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Saturdays, 8:30 am to 11:30 am, Sept.-June. Orthopedic Conference. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Continuing Medical Education. **Contact:** Dr. E. Guise (313) 876-2188. **Approved for:** 3 hours of Category I Credit.

Date: Wednesdays, 7:00 am to 10:00 am, Jan.-Dec. Emergency Medicine Conference Series. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Continuing Medical Education. **Contact:** Dr. James Nowakowski (313) 876-1552. **Approved for:** 3 hours of Category I Credit.

Date: Jan. 20-22, Hazardous Materials Emergency Medical Treatment. Location: Michigan State University. **Sponsor:** American College of Emergency Physicians (Michigan chapter) MSU Community Development, and MSU Center for Environmental Toxicology, in cooperation with MSU Colleges of Human Medicine, Osteopathic Medicine, Nursing and MSU Lifelong Education Programs. **For:** Physicians, nurses, EMTs, and other EMS personnel. **Contact:** Joan Alam, 23 Kellogg Center, MSU, East Lansing, 48824; 517/353-7822. **Approved for:** 19 hours of Category I Credit.

Date: Jan. 31-Feb. 5, Midwinter Family Practice Update. Location: Boyne Highlands Ski Resort, Harbor Springs. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School and the Michigan Academy of Family Physicians. **For:** Practicing family practitioners, physicians-in-training, allied health professionals, retired physicians. **Cost:** $295. **Contact:** Wendy L. Frisch, Promotion Coordinator, Office of Continuing Medical Education, Dept. Postgraduate Medicine and Health Professions Education, University of Michigan Medical Center, Ann Arbor, 48109, (313) 764-2287. **Approved for:** 21 hours of Category I Credit.

Date: February 3, February 18, and March 10, Everyday Health Decisions: Whose Choice and How? Location: 3:30-5:30 session — Borgess Hospital Auditorium, then 7:30-9:30 session — Downtown Kalamazoo Location each day. **Co-Sponsors:** Kalamazoo Area Council for the Humanities and Southwestern Michigan Area Health Education Center. **Cost:** $15.00 All three sessions, $5.00 one session. **Contact:** Mary Godfrey, Kalamazoo Area Council for the Humanities, Kalamazoo College, Kalamazoo 49007, (616) 383-8430. **Approved for:** 2 Category I hours per session, 6 Category I hours total for all three sessions.

Date: February 3, Clinical Researach: Experimental Drugs — How to Obtain Them (Prostaglandins). Location: Kalamazoo Hilton Inn. **Co-Sponsors:** Physician's Education Committee, The Upjohn Company and Southwestern Michigan Area Health Education Center. **Contact:** Charles L. Zeller, Jr., M.D., Director, Continuing Medical Education, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo 49007, (616) 388-7877. **Approved for:** 4 hours of Category I Credit.

Date: Feb. 6, Office Management of Chronic Musculoskeletal Pain — Part II. Location: Pain Research & Control Institute, Southfield. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine, and Pain Research and Control Institute, Southfield Rehabilitation Center. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 6 hours of Category I Credit.

Date: Feb. 7-12, Seventh Annual Seminar on Emergencies in Medicine. Location: Boyne Highlands Resort, Boyne Falls. **Sponsor:** Wayne State University Department of Surgery. **Contact:** Theresa Sokol, (313) 577-5009. **Approved for:** 23 hours of Category I Credit.

Date: February 13, "Cytologic Manifestations of Repair." Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** Willys F. Mueller, MD, Department of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours of Category I Credit.

Date: February 15-19, 1982, Third Annual Boyne Winter Imaging Seminar. Location: Boyne Highlands Inn, Harbor Springs. **Sponsor:**

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Diagnostic Radiology Department, William Beaumont Hospital. **For:** Interested physicians, sonographers, residents. **Cost:** $225 — physicians; $175 — sonographers, residents. **Contact:** Mrs. Margaret Eager, Diagnostic Radiology, William Beaumont Hospital, Royal Oak, 48072. **Approved for:** 21 hours of Category I Credit.

Date: Feb. 15-19, Emergency Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **For:** Emergency physicians, other physicians involved in emergency care, and nurses and other interested associated health professionals. **Cost:** $395 Practicing Physician; $225 Physician-in-Training; $225 Allied Health Professional; $150 Students. **Contact:** Wendy L. Frisch, promotion coordinator, Towsley Center for Continuing Medical Education, Department of Postgraduate Medical and Health Professions Education, University of Michigan Medical School, Ann Arbor 48109. **Approved for:** 36 hours of Category I Credit; 36 ACEP Credit Hours.

Date: February 15-19, Major Minors: The Subspecialties in Emergency Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan, Ann Arbor. **Sponsor:** Office of CME, Department of Postgraduate Medicine and Health Professions Education. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 764-2287. **Approved for:** 37.5 hours of Category I Credit.

Date: March 1-2, Sixth Annual Winter Pediatric Seminar. Location: Caribou Lodge, Powderhorn Ski Area, Bessemer. **Sponsor:** Marshfield Clinic and Marshfield Medical Foundation. **Cost:** $60. **Contact:** Marshfield Clinic Office of Medical Education, 1000 N. Oak Avenue, Marshfield, Wisconsin 54449 (715) 387-5207. **Approved for:** 8 hours of Category I Credit.

Date: March 14-17, Carmel, California Infectious Diseases Conference: Advances in Diagnosis and Treatment. Location: Carmel-by-the-Sea Holiday Inn, Carmel, California. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School. **Cost:** $300. **Contact:** Wendy L. Frisch, Office of CME, Towsley Center, U-M Medical Center, Ann Arbor 48109, (313) 764-2287. **Approved for:** 11.5 hours of Category I Credit.

Date: March 24, New Approaches in the Diagnosis and Management of Ischemic Heart Disease. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **Contact:** Wendy L. Frisch, Towsley Center, U-M Medical School, Ann Arbor 48109 (313) 764-2287. **Approved for:** 8.25 hours of Category I Credit.

Date: April 16-17, Spring Symposium in Radiation Oncology. Location: Towsley Center for Continuing Medical Education, U-M Medical School. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **Contact:** Wendy L. Frisch, Towsley Center for Continuing Education, Box 057, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 12.75 hours of Category I Credit.

Date: April 22-23, Eleventh Annual Critical Care Symposium. Location: Michigan Inn, Southfield. **Sponsor:** Wayne State University, Department of Surgery. **Contact:** Theresa Sokol, (313) 577-5009. **Approved for: 12 hours of Category I Credit.**

Date: April 23-25, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: April 26-30, Advanced Muscle Energy Tutorial (Below Diaphragm). Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 14-18, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine, and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn,A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 18-20, 33rd Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University Department of Surgery. **Contact:** Theresa Sokol, (313) 577-5009. **Approved for:** 12 hours of Category I Credit.

Date: July 22-26, Intermediate Course on Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Continued on page 53

And there's more proof on the way!

1982 will see the completion of the Multiple Risk Factor Intervention Trial (MRFIT)—a six-year, 12,000-patient study assessing the factors that increase risk of cardiovascular disease. For the management of hypertension, the preferred Step-2 regimen in this study is reserpine-thiazide.

In 1978, in a preliminary report presented to the Epidemiology Section of the American Heart Association (Dallas, Nov 1978), after 12 months of the trial, fewer patients (5.3%) treated with reserpine suffered depression than even the untreated control group (7.7%)!

Please see references and brief summary of prescribing information on last pages of this advertisement.

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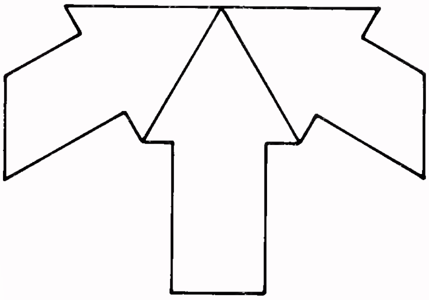
SM-2348 11/81

MEETINGS



MSMS, MSMS/A, AMA, and medical assistants

Jan. 25 — MSMS/A Mid-Year Board Meeting, MSMS Building, East Lansing, contact: Caroline Rich, MSMS headquarters.

Jan. 27 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

Jan. 28-Feb. 11, 1982 — MSMS/INTRAV South American Adventure, contact: Marce Ireland, MSMS headquarters.

Jan. 30-31, 1982 — Medical Assistants Mid-Winter Seminar, Hyatt Regency, Dearborn, contact: Caroline Rich, MSMS headquarters.

Feb. 6-13, 1982 — MSMS/INTRAV West Indies Air/Sea Cruise, contact: Marce Ireland, MSMS headquarters.

Feb. 6-13, 1982 — MSMS/INTRAV Mexican Riviera Air/Sea Cruise, contact: Marce Ireland, MSMS headquarters, 517/337-1351.

Feb. 23-25, 1982 — AMA Auxiliary Regional Cluster Meeting, for State Presidents, Presidents-elect and nominated Presidents-elect, contact: Caroline Rich, MSMS headquarters.

March 5, 1982 — Impaired Health Care Professionals: A Challenge to the Professions, Westin Hotel, Detroit, contact: Marce Ireland or Sherry Fent, MSMS headquarters, 517/337-1351.

March 7, 1982 — Medical Assistants Board Meeting, MSMS Building, East Lansing, contact: Caroline Rich, MSMS headquarters.

March 10, 1982 — MSMS Council Meeting, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

March 10, 1982 — MSMS/A Legislative Day, Civic Center, Lansing, contact: Caroline Rich, MSMS headquarters.

April 7, 1982 — Workshop for Accredited CME Providers, Long's Convention Center, Lansing, contact: Marce Ireland, MSMS headquarters, 517/337-1351.

April 8, 1982 — MSMS Conference on Sports Medicine, Plymouth Hilton, contact: Mert Scholten, MSMS headquarters.

April 14-15, 1982 — 1982 Michigan Conference on Maternal and Perinatal Health, Grand Plaza Center, Grand Rapids, contact: Katie Brewbaker, MSMS headquarters.

April 30-May 1-2, 1982 — MSMS House of Delegates, Westin Hotel, Renaissance Center, Detroit, contact: Richard Campau, MSMS headquarters.

May 3-5, 1982 — 56th Annual Convention MSMS Auxiliary, Grand Plaza, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

Salutensin® Salutensin-Demi™

(Hydroflumethiazide, Reserpine Antihypertensive Formulation)

Brief Summary of Prescribing Information (12) 10/27/78

For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

June, 1982 — AMA Convention, Drake Hotel, Chicago, contact: Caroline Rich, MSMS headquarters.

June 30, 1982 — MSMS/INTRAV Rhine River Adventure (14 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

July 11-14, 1982 — The Council Midsummer Session, Grand Traverse Hilton, contact: Warren F. Tryloff, MSMS headquarters, 517/337-1351.

July 18, 1982 — MSMS/INTRAV Alpine Adventure (15 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

Other meetings

Feb. 17, 1982 — Michigan Academy of Family Physicians, Board Room, MSMS headquarters, contact: MAFP 517/482-7410.

Feb. 20, 1982 — Michigan Association of Emergency Medical Technicians, Johnson Room, MSMS headquarters, contact:- Bob Farrow 626/531-7357.

March 3, 1982 — American College of Emergency Physicians, Board, MSMS headquarters, contact: ACEP 517/332-6500.

March 20, 1982 — Michigan Association of Emergency Medical Technicians, MSMS headquarters, contact: Bob Farrow 616/531-7357.

April 5, 1982 — Wayne County Medical Society 61st Annual Beaumont Lecture, Bon Secours Hospital, Grosse Pointe, contact: Wayne County Medical Society.

May 5, 1982 — American College of Emergency Physicians, MSMS headquarters, contact: ACEP, 517/332-6500.

May 15, 1982 — Michigan Association of Emergency Medical Technicians, MSMS headquarters, contact: Bob Farrow 616/531-7357.

May 26-27, 1982 — Annual Gull Lake Conference of MSMS Committee of Maternal and Perinatal Health, MSU Gull Lake Conference Center, Hickory Corners, contact: Katie Brewbaker, MSMS headquarters, 517/337-1351.

CATEGORY I/Continued

Date: July 30-Aug. 1, **Arrhythmias and Cardiac Ischemia: Diagnosis and Management. Location:** Boyne Mountain Resort, Boyne City. **Sponsor:** International Medical Education Corporation. **For:** Physicians, nurses and technicians. **Cost:** Physicians — $245, Nurses and technicians — $130. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, 64 Inverness Drive East, Englewood, CO 80112 (303) 773-1144 or 800-525-8646. **Approved for:** 13 hours of Category I Credit.

Date: Aug. 23-27, **Tutorial on Direct Action Thrusting. Location:** Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: October 15-16, **Cardiac Rehabilitation. Location:** Hyatt Regency Dearborn. **Sponsor:** International Medical Education Corporation. **Cost:** $245. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive East, Englewood, CO 80112 800-525-8651 or 303-740-8445, ext. 123. **Approved for:** 13 hours of Category I Credit.

Date: Oct. 25-29, **Craniosacral Technique. Location:** Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of category I Credit.

Date: Nov. 1-5, **Advanced Muscle Energy Tutorial (Above Diaphragm). Location:** Lansing

Continued on page 63

ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine

Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

1 tablet b.i.d.

SUPPLIED

Bottles of 100 and 1000 scored 50 mg. tablets.

References:

1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

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Medical Arbitration Program saves time; settlements near those reached in courts

By Deborah Zannoth
East Lansing

The MSMS Bureau of Economics continues to present information and data regarding the malpractice issue in Michigan. The following article reviews the experience to date of the Michigan Arbitration Program and makes some comparisons with malpractice cases adjudicated through the court system.

The Michigan Medical Arbitration Program was enacted into law in 1975 and implemented on January 1, 1976. The program offers voluntary binding arbitration as an alternative to litigation.

The Michigan arbitration system is organized to cover all disputes arising out of medical treatment, except disputes over fees charged. For an arbitration agreement to be valid, it must be signed by all parties and must cover that stay or treatment which is the source of the dispute and must not have been terminated within the 60 day cancellation period.

Since January 1, 1976, a total of 303 arbitration cases has been filed in Michigan. Of these, 136 have been closed and 167 are still pending (as of Sept. 30, 1981).

Of the 136 closed cases, 107 were settled before reaching the arbitration panel. Thirty-six of the 107 cases were withdrawn. The remaining 71 achieved a settlement.

Twenty-nine cases actually completed the arbitration process, but the panels denied awards in 22 of the cases.

Year	Total Cases Filed	Closed	Pending
1976	2	2	0
1977	19	18	1
1978	54	49	5
1979	86	40	46
1980	86	25	61
1981	56	2	54
	303	136	167

Arbitration saves time

However, the average time span involved has been considerably less for the arbitration program than for those cases in litigation:

> From date of filing of the demand to the award: 17 months* (including 180 day discovery and 30 day award periods)
>
> From date of filing of the demand to settlement: 16 months
>
> From date of filing of the demand to withdrawal: 11 months
>
> *In comparison, through litigation the average time between reported date and closure is 32 months.

In the cases that have been determined by the arbitrators, the average length of the hearings has been two days. The costs of proceedings (arbitrator's fees and expenses, administrative expenses, tape recordings, etc.) have averaged $1,545.94 per awarded case.

Arbitration data are not available regarding physician characteristics, geographic distribution of cases or others involved in the injury. However, it is interesting to note that the average dollar amount being awarded is comparable in both arbitration and litigation, as well as the average number of cases in which no award or indemnity is paid.

The Michigan Insurance Bureau is currently planning a study to assess not only the Michigan Medical Arbitration Program but also the malpractice climate, particularly in Michigan hospitals. The Insurance Bureau anticipates the research to begin in January.

The net result is that 47 percent (the 36 cases withdrawn and the 22 cases in which a claim was denied) of the closed cases involved in the Michigan Arbitration Program have resulted in no award.

In comparison, of the 1,545 malpractice cases completing litigation in the same period (January 1975 to August 1981), 42 percent have resulted in no indemnity being paid.

These percentages are very close for both arbitrated and litigated cases.

The settlements in the 71 cases closed before reaching arbitration panels ranged from $363 to $220,000, with the average $21,466.03.

In the 29 cases which have gone to arbitration, awards have been made to seven claimants, with the amounts ranging from $250.40 to $20,067.00. The average award in those cases is equal to $10,152.40. In comparison, for the 1,545 malpractice cases completing litigation the average indemnity has been $10,844.

Again, the figures for arbitration and litigation are similar.

Ms. Zannoth is assistant to the MSMS Bureau of Economics.

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Be sure you know updated rules on filing birth, death records

Administrative rules related to the completion, filing and registration of birth and death records have been promulgated by the office of Vital and Health Statistics of the Michigan Department of Public Health. The rules took effect November 25, 1981, and establish standards for entering information on vital records as well as criteria for determining the acceptability of vital records for filing.

The purpose of the rules is to insure that vital records accepted for filing and registration will be of sufficient quality and credibility to provide a valid legal record of the event and to provide medical, public health and statistical information concerning it.

The rules require that vital records be prepared using a typewriter with a black ribbon, or by printing legibly in permanent black ink. All signatures must be original and handwritten in permanent black ink.

For birth certificates, the medical certifier must provide the medical information required and certify to the facts of birth within 72 hours after the birth of the child.

For death certificates, the physician's responsibility is to complete and certify to the medical facts of death including the date and place of death when a death certificate is presented to him or her with the following information completed: 1) Name of the deceased, 2) Sex of the deceased, and 3) Address of the deceased including the city, village or township and county. The medical certification must be completed not later than 48 hours after death.

Once information is recorded on a typewritten document, minor changes may be made only by using a lift-off process. Records with signs of erasure, image overlay, or white-out are not acceptable for registration except for the information designated for statistical or health use on the birth record. Dates must be written out and cannot be in numerals.

If a vital record is not accepted by the local registrar the person responsible for preparing the document must prepare a new record acceptable for filing. *This process will result in the medical certifier being requested to sign a second record.*

Copies of the rules and instructions for completing birth and death records are available by contacting George Van Amburg, State Registrar, Office of Vital and Health Statistics, Michigan Department of Public Health, P.O. Box 30035, Lansing, 48909.

AMA has new document on determining death

"Guidelines for the Determination of Death," part of a report from the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, has been published in the *Journal of the American Medical Association* (Nov. 13).

The document is a summary of currently accepted medical practices for the determination of death, both cardiorespiratory and neurological (brain death).

The criteria were developed by more than 50 physicians from the fields of neurology, neurosurgery, electroencephalography, critical care medicine, anesthesiology, and legal medicine. Taking into consideration new technologies in the laboratory confirmation of the diagnosis of death, they are the first update of standards for brain death since 1968.

The criteria are divided into two sections:

A. An individual with irreversible cessation of circulatory and respiratory functions is dead.

B. An individual with irreversible cessation of all functions of the entire brain, including the brainstem, is dead.

Each section, is supplemented by an explanation of medical practices which may be used in determining cessation of functions and irreversibility, both of which must be demonstrated for a diagnosis of death. An individual presenting the findings in *either* section A or B is dead.

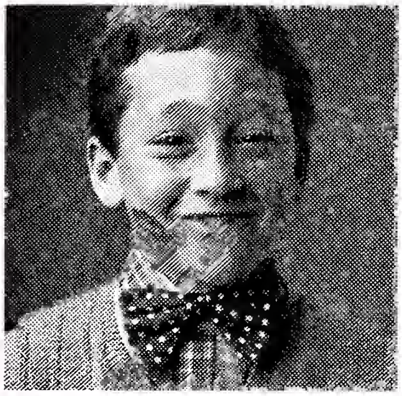
Of particular interest in the report is a discussion of medical conditions which can complicate the application of the neurological criteria. For example, drug intoxication, total paralysis and certain coma states can stimulate death both in appearance and on some diagnostic tests.

In addition, the neurological criteria may not be reliable in cases involving hypothermia (body temperature less than 90°F.). Hypothermia can mimic death while protecting the body against neurological damage by enabling the brain to survive with less oxygen.

The report also warns physicians to be cautious in applying the neurological criteria in the presence of shock in children younger than five years.

The "Guidelines for the Determination of Death" were developed to help implement the Uniform Determination of Death Act, a model statute intended to end the confusion caused by laws differing from state to state. The statute was drafted by the American Bar Association, the American Medical Association, the National Conference of Commissioners on Uniform State Laws, and the President's Commission.

To date, four states have adopted this statute: Vermont, Mississippi, Idaho and Colorado. At this time, the statute awaits signature by the Mayor of the District of Columbia.



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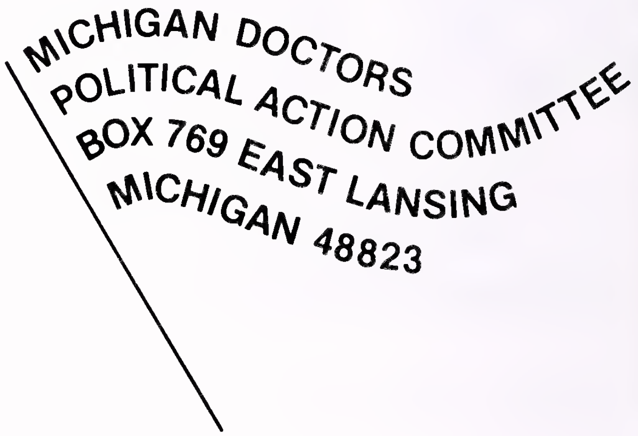
MDPAC: de Tocqueville would have approved

By Harvey Halberstadt, MD
Troy



It was necessary during colonial times for communities to be united by religious, national, ethnic, and class interests. Inherent in such assemblies was the voluntary association.

Alexis de Tocqueville wrote that: "The morals and intelligence of a democratic people would be in as much danger as its commerce and industry if ever a government wholly usurped the place of private associations." He had observed in his travels through America in 1830 that: "Americans of all ages, all stations of life, and all types of dispositions are forever forming associations."

Alexis de Tocqueville concluded that: "In countries where such associations do not exist, if private people do not artificially and temporarily create something like them, I see no other dike to hold back tyranny of whatever sort, and a great nation might with impunity be oppressed by some tiny faction or by a single man."

In 1981 one such voluntary group is the political action committee.

Perhaps no institution of today's American politics is less understood than the political action committee

---

Doctor Halberstadt is a psychiatrist and member of the MDPAC board.

Continued on page 61

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established by the Federal Election Campaign Act of 1971. It is misunderstood even though committees have played a role since colonial America. It was an early custom for people to organize to promote and to protect their interests.

In 1981 there is a fear that PACs will corrupt elected representatives even though the assumption that most elected officials are corruptible has not been tested. Organizations such as Common Cause that embrace public causes and are political are not perceived with suspicion. Despite such suspicion there are over 200 PACs representing a broad spectrum of organizations.

The American Medical Association created AMPAC 20 years ago and held its 20th anniversary with a convention in Washington, D.C. from Sept. 16 through Sept. 18, 1981.

AMPAC began its efforts 20 years ago with a group of farsighted physicians, a type of leadership that was maintained during these years. It began in 1961 with a total membership contribution of $250,000 which has increased to about $2,000,000 in 1981. As AMPAC acquired experience its methodology gained in sophistication and effectiveness.

In 1976 the United States Supreme Court ruled in Buckley v. Valco that a PAC can contribute $5,000 to a political candidate providing that it acts "independently of control or direction by the parent corporation or the national or regional union." The court also authorized "independent" expenditures to candidates' campaigns if those services are provided without the knowledge or request of the candidate or his representatives. There are no restrictions on the amounts spent for independent expenditures.

In July, 1978 the AMPAC staff developed a list of candidates who might benefit from an independent expenditure program. Two approaches were employed. The first was a full-page advertisement in local editions of national magazines such as *Time* and *Sports Illustrated*, and the second was campaign buttons for selected candidates. Of the 27 candidates chosen, 24, or 89 percent were elected.

In 1980 the AMPAC staff created a television commercial shown in 20 congressional districts and mailed brochures on 10 individual congressional candidates to their constituencies. Research showed that the commercials were successful in improving voters' attitudes toward the candidates especially by undecided voters. The direct mail affected voters' beliefs positively, and in one district, by as much as 6 percent. Two Michigan Congressmen benefited, William Broomsfield and Hal Sawyer.

Michigan State Medical Society has MDPAC. In terms of percentage of doctors practicing in the state who contribute to PAC, Michigan ranks 18 among the states. There are many critical issues concerning medicine that are being resolved by law and by courts. It is imperative that we become members and actively participate.

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DEATHS

Isla G. Depree, MD
Grand Rapids

Isla G. Depree, MD, of Grand Rapids died Oct. 20. She was 83. Doctor Depree received her MD degree from the University of Michigan in 1922, and maintained an obstetrical and gynecological practice in Grand Rapids for 43 years until her 1967 retirement. She was active on the staffs of both Blodgett Memorial Medical Center and St. Mary's Hospital. In 1935 Doctor Depree built a cabin on Drummond Island, and continued to practice there during summers for many years. Doctor Depree was a member of the American College of Obstetricians and Gynecologists, and in 1974 was awarded the Distinguished Alumni Award from Grand Rapids Junior College. At her 50th medical class reunion, she was inducted into the Michigan Alumni Association Emeritus Club.

Lawrence W. French, MD
Grosse Pte. Farms

Lawrence W. French, MD, of Grosse Pointe Farms, died Sept. 30. He was 50. Doctor French earned his medical degree from Wayne State University, and served as an Air Force flight surgeon in 1958 and 1959. A pediatrician in private practice, he was past president of the Detroit Pediatrics Society and on the boards of directors at St. John Hospital and Children's Hospital.

Gayland L. Hagelshaw, MD
Bay City

Gayland L. Hagelshaw, MD, Bay City radiologist died Nov. 4 at the age of 76. Doctor Hagelshaw practiced medicine for more than 50 years. He attended West Point Academy, completed his undergraduate work at Olivet College and graduated from the University of Michigan Medical School. During WWII, he served as a Colonel with the army medical corps. He was a member of the Radiology Society of North America, and was past president of the Bay County Medical Society. Doctor Hagelshaw was on the staff of Bay Medical Center, a past chief of staff of the former Mercy and General Hospitals and also practiced radiology at the Standish Community Hospital. He also was a board member of the Bay Medical Care Facility.

R. Fred Hauer, MD
Howell

R. Fred Hauer, MD, of Howell died Nov. 10. He was 58. Doctor Hauer was director of the substance abuse center at McPherson Community Health Center and chief of staff at McPherson Community Hospital, where he had been on staff since 1953. Doctor Hauer was a member of the Tri-County Academy of Family Practice, and was past president of the Livingston County Medical Society. A general practitioner, Doctor Hauer earned his MD degree from Marquette Medical School of Wisconsin in 1950.

Felix J. Kemp, MD
Bloomfield Township

Felix J. Kemp, MD, of Bloomfield Township passed away Oct. 27 at the age of 78. Doctor Kemp maintained a family medical practice in Pontiac for 40 years, until he closed it four years ago to become involved in the employee health services program at St. Joseph Hospital. A 1936 graduate of the Creighton University Medical School, Doctor Kemp was an active member of the Oakland County Medical Society, and was affiliated with both St. Joseph Mercy and Pontiac General Hospitals.

William R. Latchaw, MD
San Diego, California

William R. Latchaw, MD, of San Diego, died Oct. 16. He was 78. A former resident of Jackson, Doctor Latchaw had been an administrator at Southern Michigan State Prison Hospital. He received his MD degree from the University of Michigan School of Medicine in 1928, and specialized in proctology. Doctor Latchaw was a member of the American Proctologic Society and the New England Proctologic Society.

Walter Levick, MD
Grosse Pointe Shores

Walter Levick, MD, of Grosse Pointe Shores was killed in an auto accident Oct. 30. He was 50. Doctor Levick practiced psychiatry at St. John Hospital, Detroit; Bon Secours and Cottage Hospitals, Grosse Pointe; and South Macomb Hospital. A native of Toronto, Doctor Levick had been affiliated with East Point Medical Associates in Harper Woods for 16 years. He earned his medical degree from the University of Ottawa Medical School.

Herbert G. Levin, MD
Southfield

Herbert G. Levin, MD, of Southfield died Oct. 17 at the age of 61. Doctor Levin received his MD degree in 1943 from the University of Michigan Medical School, and specialized in internal medicine. In addition to his Southfield practice, he was affiliated with Sinai Hospital of Detroit. The Doctor Herbert G. Levin Fund for Depression Research has been established by Doctor Harold Shapiro, University of Michigan president. Memorial contributions can be made to the fund c/o School of Medicine, University of Michigan, Ann Arbor, 48109.

Delbert P. Nachazel, MD
Bloomfield Hills

Delbert P. Nachazel, MD, Bloomfield Hills, died October 18. He was 48. A 1958 graduate of the Medical College of Wisconsin at Milwaukee, Doctor Nachazel was an ophthalmologist. He was on the staffs of Harper-Grace, Children's, St. John, St. Mary's, Henry Ford, Oak Wood and William Beaumont Hospitals.

Milton R. Palmer, MD
Detroit

Milton R. Palmer, MD, of Detroit, died Oct. 5 at the age of 66. Doctor Palmer received his medical degree from Howard University College of Medicine, Washington, DC, in 1944. He was a psychiatrist.

William L. Purves, MD
Detroit

William L. Purves, MD, of Detroit, died Sept. 12 at the age of 74. Doctor Purves, a psychiatrist, earned his medical degree at Northwestern University in 1933. He spent six years in the military as a medical officer from 1940 until 1946. Doctor Purves was affiliated with Detroit Receiving Hospital, and was a member of the Michigan Society of Neurology and Psychiatry, the American Psychiatric Association and Phi Beta Pi medical fraternity.

CLASSIFIED

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DEATHS/Continued

Howard G. West, MD
Detroit

Howard G. West, MD, Detroit, died Nov. 12 at the age of 79. A family practitioner, Doctor West received his medical degree in 1932 from Wayne Medical College, now Wayne State University School of Medicine. He joined the staff of Grace Hospital in the late 1930s, then moved to Harper-Grace Northwest when it opened in 1942. His affilation with Harper-Grace Hospital exceeded 40 years.

CATEGORY I/*Continued*

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Date: Nov. 8-10. Manual Medicine to the Extremities. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

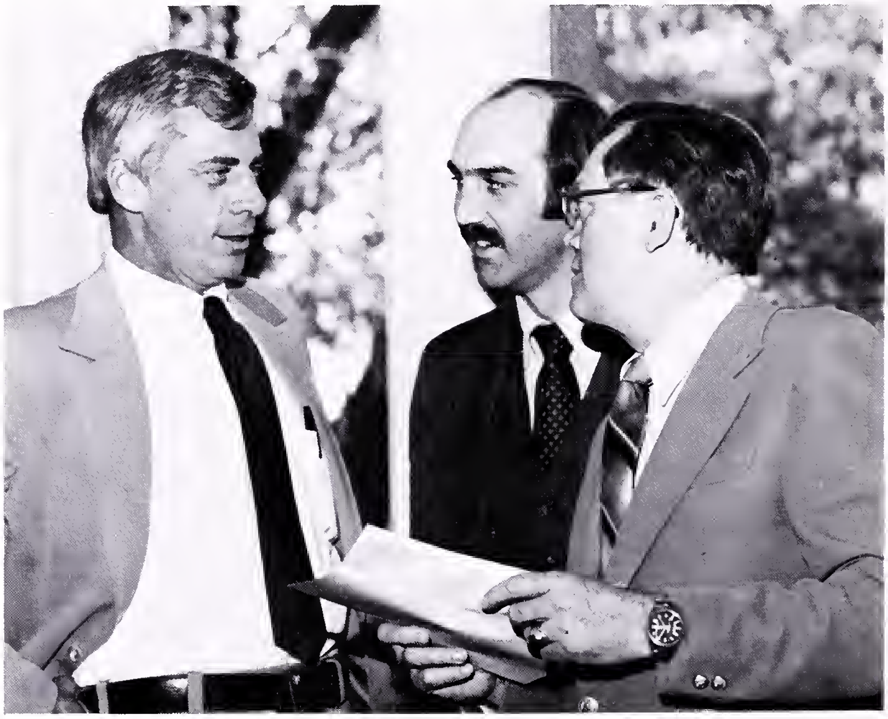
Date: Dec. 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Assembling the Medicaid primary sponsor work team

The Medicaid primary sponsor pilot program in Wayne County needs much promotion and coordination to get underway this year. Thus, Department of Social Services Director John T. Dempsey, PhD, assembled a large cast for planning sessions at MSMS headquarters. They included, from left, Bruce Hansen of the Medical Services Administration, project work team co-director; Allen F. Turcke, MD, Flint, chairman, MSMS Medicaid Liaison Committee; David Weiner, representing Rep. David Hollister's office; Robert Little, Wayne County Department of Social Services, and Charles Murphy, DO, of the Michigan Association of Osteopathic Physicians and Surgeons.

A key figure in the legislative go-ahead for the Medicaid pilot project is Sen. Stephen V. Monsma, D-Grand Rapids. He and Rep. David Hollister approved the pilot project in October.

Sherry N. Wellman of the MSMS staff also is project co-director. Here she and Doctor Turcke confer.



Others on the planning sessions are, from left, Jay Endsley, director, Office of Health and Medical Affairs; Vernon Smith, director, MSA Bureau of Medicaid Information and Policy Development, and Paul M. Allen, MSA director.

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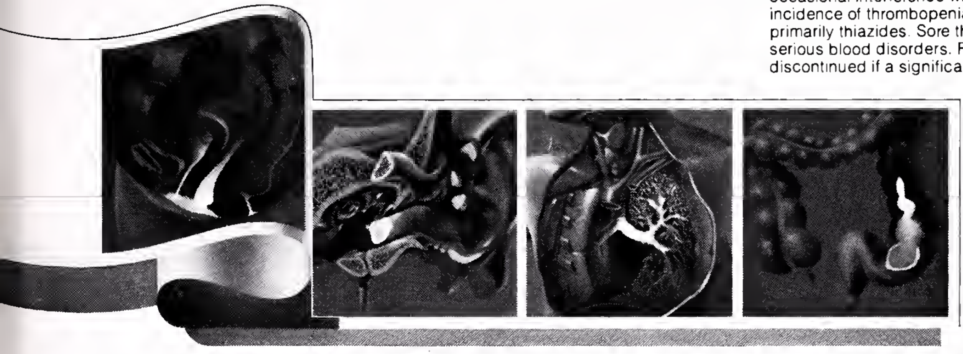

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Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
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Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

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Please see previous page for summary of product information.

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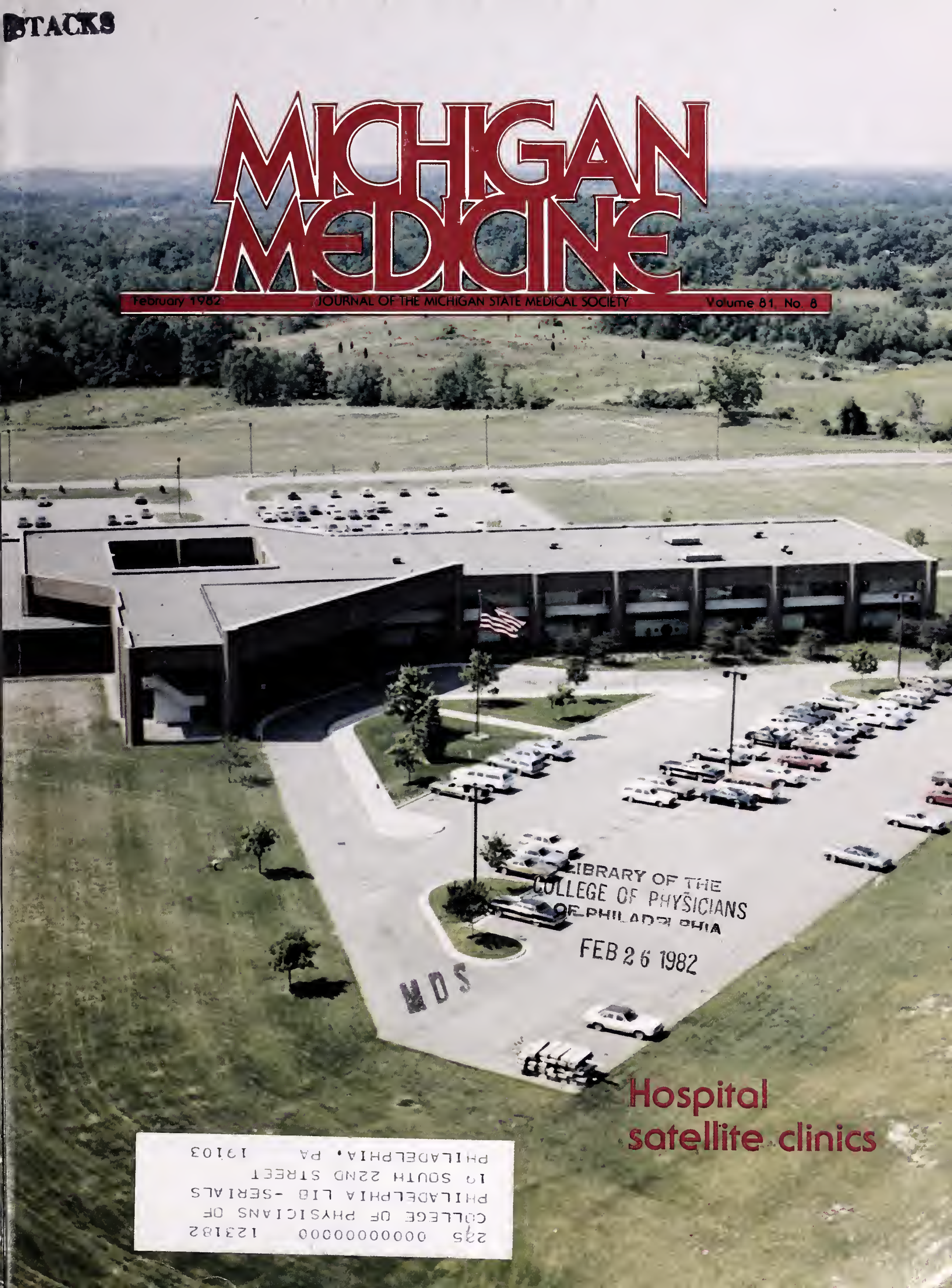
MICHIGAN MEDICINE

February 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 81, No. 8



Hospital satellite clinics

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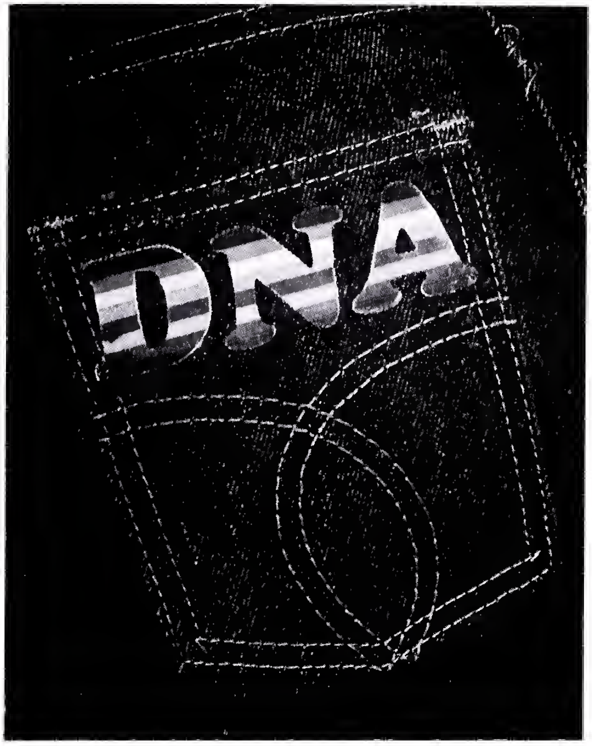

“DESIGNER GENES”

1982 Michigan Conference on Maternal and Perinatal Health

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April 14

New Horizons in Perinatal Diagnoses
Michael M. Kaback, MD, UCLA
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Elizabeth J. Thomson, RN, University of Iowa
Evaluation of Fetal Wastage
Sherman Elias, MD, Northwestern University
Recent Advances in Human Cytogenetics
James V. Higgins, PhD, MSU
Prenatal Diagnosis of Congenital Anomalies by Ultrasound
Peter Grannum, MD, Yale University
Recognition and Diagnosis of Sick Infants with Inborn Errors
Henry L. Nadler, MD, WSU
Diagnostic Evaluation of the Dysmorphic Child
Murray Feingold, MD, Tufts University

April 15

Population Screening and Perinatal Diagnosis for Metabolic Abnormalities
Michael M. Kaback, MD, UCLA
Serum Alpha Fetaprotein Screening
James E. Haddow, MD, Foundation for Blood Research, Scarborough, MA
Teratogens: Environmental Hazards for Fetal Development
James W. Hanson, MD, University of Iowa
Michigan Genetic Disease Program
William D. Young, PhD, MDPH, Lansing
Counseling Process in a Genetics Clinic
Diane Baker, MS, U-M
The Law and Genetics
Margery W. Shaw, MD, JD, Health Law Institute, Houston
Ethical Considerations in Genetic Screening
Joseph Fletcher, STD, D. Litt., University of Virginia

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MICHIGAN MEDICINE
Hospital satellite clinics

Henry Ford Hospital's West Bloomfield Center is among five satellite clinics established by the hospital in southeast Michigan since 1974. It provides adult and pediatric care, 24-hour emergency care, ambulatory surgery, laboratory and x-ray services. Trends in growth of hospital satellite clinics are the subject of this month's special report. **(HFH photo)**

MICHIGAN MEDICINE

February 1982, Volume 81, No. 8

Special report

68 Hospitals' satellite clinics are a primary manifestation of the trend to more care delivered in the ambulatory setting. And there are likely to be more of them established as health care and political leaders strive to reduce hospital costs. The proliferation of satellite clinics dismays some health care professionals. Others see advantages in it. Whatever the view, this special report offers Michigan physicians the opportunity to learn more about satellite clinics, their locations, the future, and the viewpoints; Dwight E. M. Angell; Si Nahra, PhD; Kenneth Herrington, MD; Robert J. Toteff, MD; Donald P. Potter

Features

82 MD-owned professional liability insurance companies see soaring numbers of lawsuits and inflating settlements

86 1981 — the medical year in review

88 Genetic counseling and prevention of birth defects — Report B of the AMA Council on Scientific Affairs

100 The Michigan Department of Public Health reports on its study of the frequency of mild reactions to DTP vaccinations; Byron S. Berlin, MD

107 Private practice option now available in health manpower shortage areas; Alice Pletz

122 Book review; *The Law of Medical Practice in Michigan;* Louis E. Heideman, MD

Departments

67 Letters

84 Newsfronts

104 Views; John R. F. Ingall, MD

112 News; Sheri W. Greenhoe

114 New members

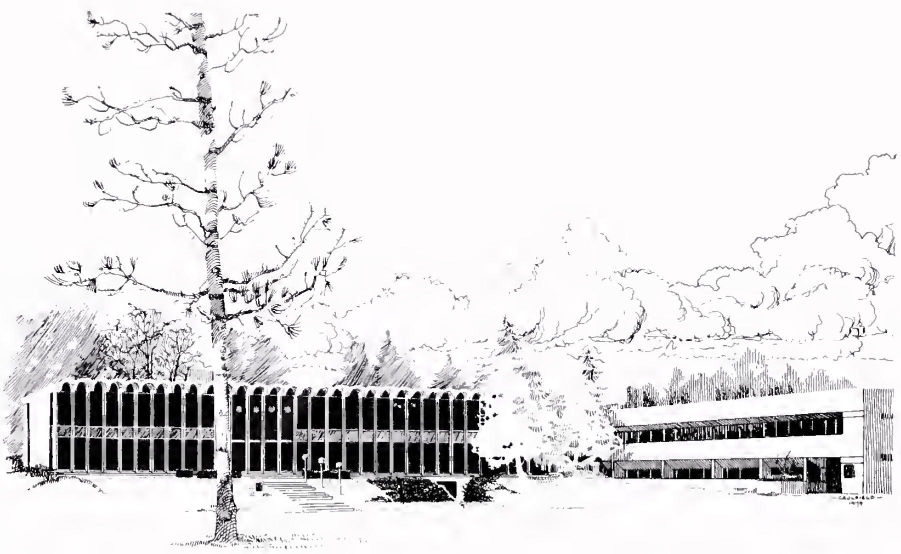
118 Meetings

119 Category I courses

124 Classified ads

125 Ad index

126 Medico-legal; A. Stewart Kerr



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Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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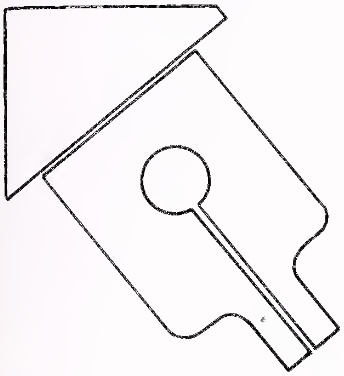
LETTERS



USAF thank-you

Thank you!

We have just concluded what I consider the most successful recruiting year in Air Force history. We met the challenge of increased requirements and did so with quality. We enlisted nearly 77,000 nonprior service men and women and over 67,000 (87.7%) were high school graduates. Both figures are the highest in several years.

Our health professions program requirements (physicians, dentists, nurses, and other health care professionals) were all surpassed with the exception of the physician program. Faced with an increased requirement in the critical physician specialties, we attained 91 percent of our physician objective — the highest ever.

The dedicated efforts of our recruiters and the critically essential direct and indirect support of leaders like you provided a solid foundation for Air Force Recruiting Service. In FY 82, we will see an ever-increasing need for quality people in all programs with special emphasis on our enlisted program, physician specialists, and engineers. We also face a greatly increased requirement for both pilots and navigators.

As you can see, we do have a challenging job ahead of us this year. Quality will be paramount as we seek young men and women from an increasingly smaller pool of qualified applicants. The support you provide through your leadership position in the community greatly enhances our ability to achieve our recruiting requirements. Your continued support is essential to our future success. Together we can continue to provide the United States Air Force with its greatest asset, highly qualified and dedicated people.

Again, I thank you on behalf of all the 4,000 men and women of Air Force Recruiting Service.

Thomas C. Richards
Brigadier General, USAF
Commander
Randolph Air Force Base, Texas

"Illness strikes"

I recently received the samples of the "If Illness Strikes" brochure. Distribution of this brochure would certainly seem to be a worthwhile effort.

I wonder if any consideration was given to possible distribution through AAA or other travel agencies.

Richard C. Dew, MD
Ypsilanti

Editor's note: MSMS has worked with the Michigan Department of Transportation to distribute the brochures to travelers throughout the state. Copies are available from Mert Scholten at MSMS headquarters and can be bought in large quantities at a cost of $32.50 per 500 copies.

Statistics helpful

I read with great appreciation Deborah Zannoth's article on page 624 of the *Michigan Medicine*, November, 1981.

The statistics that you present are most helpful.

I believe that the article could be even more helpful if you were to determine the population base of each of the zip code areas in Table VII and state the number of claims per 100,000 population or 10,000 population, whichever would seem to be feasible. This would lend some comparability to the data and I'm wondering if it might not even devastate a myth that Wayne County is the worst of all possible places to be in Michigan for malpractice. Perhaps that is so, but I can't see that from the data as it is now presented.

Wilmer M. Rutt, MD
Medical Director
Fairlane Center
Henry Ford Hospital
Dearborn

Editor's note: Zip code data now retained by MSMS relates to the physician's place of practice which is not always the injury site. MSMS is compiling new data on the number of physicians per zip code. Doctor Rutt's and other members' suggestions are appreciated and MSMS will share further data as studies continue.

Copy, please

MEDICAL CARE REVIEW, now in its 37th year of publication, welcomes review copies of materials of a medical care interest. We are enclosing a recent issue for your attention. Our international readership includes members of the health professions, insurance organizations, students and various government officials.

May we receive a copy of:

"Attitudes Toward Health Care Issues of the General Public and Physicians in the State of Michigan," (MSMS public and physician attitude report of November, 1981) for review and any future medical care publications.

Thank you for your consideration of this request.

Jean A. Thorby, Editor
MEDICAL CARE REVIEW
University of Michigan
Bureau of Public Health Economics

More letters on page 111

SPECIAL REPORT

Satellite clinics: the issues are competition, quality of care, and costs

By Dwight E. M. Angell
Troy

The rapid proliferation of hospital owned and operated ambulatory clinics, especially in Southeastern Michigan, has irked and threatened a number of physicians. But the conflict — physicians versus hospitals — is difficult to judge. For example, there is little agreement as to the real villain: doctors point the finger at hospitals claiming unfair competition. The hospitals claim that problem rests with the reimbursement system and that the clinics meet a real need.

But even a basic definition of an ambulatory clinic is still a problem. Should it include certain health maintenance organizations, multi-specialty group practice, any group practice, free-standing emergency room, and hospital satellite clinics? One hospital association is doing a pilot study on ambulatory clinics and has yet to find a working definition that would encompass all the above types.

But physicians are most irritated about the hospital operated satellite clinics. In the seven county area of southeast Michigan, there are 29 such clinics, most having opened for patients in the last three years.

The establishment of ambulatory satellite clinics is not the overnight brainchild of one hospital, but rather a slow, evolutionary change in the direction of hospitals and to some extent, physicians.

Hospitals in the 1970s were faced with increased pressures on their main staple, inpatient services. There were the PSROs; Utilization Review; debedding legislation; Michigan Blue Cross-Blue Shield and, eventually, academic studies demonstrating that less expensive, but more appropriate care could be rendered outside the inpatient setting.

Mr. Angell is a free-lancer in the Detroit area. His regular Issues and Angles feature is given over this month to this Special Report.

Some hospitals reacted by looking toward new ways to maintain or increase revenues as well as expand service areas. For example, inner city hospitals, who feared that the exodus of physicians and patients to the suburbs would hurt, built clinics in new expanding suburbs. The idea, of course, is to have the clinics act as funnels for potential patients. And hospitals have been diversifying in other ways: home health services, psychiatric and substance abuse services.

Other hospitals built ambulatory clinics because their emergency rooms were overflowing with non-emergency cases.

But ambulatory clinics also represent how physicians' practices have changed in the last 30 years. Not until the 1960s was the American Medical Association willing to endorse the concept of group practice and multi-specialty groups. Before then, the AMA believed in solo practice and that physicians should not be part of any organization. That has obviously changed. One health care observer notes that probably less than 10 percent of physicians in the Detroit area are solo practitioners.

In the 70's, with the state and federal backing of health maintenance organizations, more and more physicians joined together, either under one roof or at least as part of an organized structure.

One other factor, though its effect is difficult to measure in Michigan, is that the population is remaining stagnant while the numbers of new physicians is rapidly increasing. The resulting competition for patients may be exacerbated by establishment of a hospital's satellite clinic in that area.

Henry Ford Hospital was among the forerunners in ambulatory care in Michigan, opening its first suburban "satellite" center in 1974 in Troy, above. Other larger centers were opened in 1975, and two more were added to the system in 1980. More than 100 full-time physicians and dentists maintain their practices in the suburban HFH ambulatory care centers. In 1981 the satellites had a combined total of 459,000 outpatient visits.

For ambulatory clinics

Advocates argue that ambulatory clinics (satellite) are justifiable because there is a real need. If a need didn't exist, they say, then the health planning agencies which had to review their certificates of need, would not have passed on the clinics. Some of the clinics were placed where a shortage of physicians existed. Some clinics offer better hours; evening, weekend, even 24-hour service for both emergency and non-emergency cases.

In addition, the clinics can offer a whole range of ancillary services (X-ray, lab) all under one roof. That eliminates the problem where a patient must drive from place to place for such services. Consultation with physicians of various specialties is also available within feet, not miles.

But the clinics also are an acknowledgement that some services can be provided more cheaply in outpatient settings than by inpatient facilities, thereby lowering costs.

Michigan Blue Cross Blue Shield is considering a major program to pay for over 100 different types of surgeries when they are performed in ambulatory clinics, but not paying for these procedures when they are done in an inpatient setting. The Blues are also considering reimbursement incentives to cover the additional overhead costs a physician incurs when doing surgery in the office.

Against ambulatory clinics

There are many physicians who are not affected by the establishment of such clinics. But those that are, who are primarily private practitioners, argue that the clinics represent unfair competition and cite two major reasons to back their claims.

One is that the clinics, owned and operated by hospitals which are non-profit and therefore enjoy tax benefits, don't have to pay taxes on the building. Physicians in other clinics have to pay. MSMS Councilor Kenneth J. Ray, MD, Trenton, former president of the Wayne County Medical Society, says that his five member group practice pay about $18,000 a year in taxes.

Second, and most important, is that under the present reimbursement system satellite clinics can receive more revenue for providing the same services as does a physician in his private office. This is because the clinics charge not only the professional fee but also a facility fee (a portion of the total costs involved in running a hospital). The result, says Doctor Ray, is that charges are higher for the patient, and therefore health care costs may increase for the entire system.

Patric E. Ludwig, president of the Michigan Hospital Association, agrees that clinic prices for some services are probably higher than those charged for the same services performed by physicians in their own offices.

Outcome

There is much talk from critics of satellite clinics, but so far little action. MSMS is studying the issue. There is talk of lawsuits and/or legislated action.

But the Greater Detroit Area Hospital Council claims that no one really knows the answer. That is, no one yet knows whether the quality of care is better or worse in such clinics, if prices are too high or too low; if they are cost-effective or not.

Greater Detroit Area Hospital Council pinpointing satellite clinic growth trends

From the Greater Detroit Area Hospital Council

Over the course of the last 50 years, health professionals have delivered increasing amounts of ambulatory health care in organized settings ranging from clinics and group practices to hospital-owned or -affiliated ambulatory care centers.

Consider the following:

- Nationally, there has been over a 100 percent increase since the mid 1960's in the number of physicians practicing in groups.
- By 1978, 65 percent of physicians in Michigan practiced in organized settings (25.5 percent in groups and 39.6 percent were employed by others).
- Between 1965 and 1976, hospital outpatient visits more than quadrupled nationally.
- Since the mid 1970's, 26 decentralized ambulatory care programs and facilities have been established by hospitals in Southeastern Michigan.

This growth in organized ambulatory health care has raised numerous public policy questions.

Among the issues being debated are: how much ambulatory care is needed; what is the best form of ambulatory care delivery; is ambulatory care a substitute for inpatient care or an additive health service; what degree of integration should occur between inpatient and ambulatory health care services; and, how should third party financing support cost-effective health service delivery.

Resolution of these issues has important implications for physician-hospital relations, financing of ambulatory health care services, utilization of inpatient facilities and many more.

Table 1
Ambulatory Care Programs Developed by Hospitals At Decentralized Sites in Southeastern Michigan Since 1975, Their Location and Status

Hospital	Location	Status
Bi-County Community Hospital	Shelby	Open
*Bon Secours Hospital	St. Clair Shores	Open
	Eastland	Open
Detroit-Macomb Hospital Assoc.	Detroit/Jefferson	Open
*Henry Ford Hospital	Bloomfield	Open
	Fairlane	Open
	Utica	Open
	Sterling Heights	Open
*McPherson Medical Center	Brighton	Open
Oakwood Hospital	Sumpter	Open
PCHA/Oakwood	Canton	Open
	Woodhaven	Under Construction
Pontiac General Hospital	Waterford	Open
*Pontiac Osteopathic Hospital	Oxford	Open
	Milford	Open
*Providence Hospital	South Lyon	Open
	Novi	Open
Riverside Osteopathic Hospital	Exeter	Open
St. John Hospital	St. Clair Shores	Open
*St. Joseph/Ann Arbor	Ann Arbor	Open
*St. Joseph/Mt. Clemens	Shelby	Open
	Chesterfield	Open
Samaritan Health Center	Detroit/Fenkell	Open
	Detroit/E. Grand Blvd.	Open
	Detroit/E. Warren	Open
	Detroit/Jefferson	Open
	Detroit	Site Undetermined
University/Chelsea Hospitals	Chelsea	Open
William Beaumont Hospital	Ferndale	Open

****Denotes Pilot Study Participant***

Despite an awareness of the growth of organized ambulatory care, our understanding of that growth and its ramifications is rudimentary and based largely on impressionistic observations with limited information.

The literature on ambulatory care is dominated by discussions on what particular institutions have developed for their specific situations, the various types of arrangements attempted, and the financial implications of undertaking hospital/group practice sponsored organized ambulatory care programs.

To date, only limited research and performance evaluations have been conducted concerning the various organizational approaches for delivering ambulatory health care services. This is due to a dearth of generally-agreed-upon terms and definitions which can be used in classifying and categorizing ambulatory care activities.

In response to this informational need, the Greater Detroit Area Hospital Council (GDAHC) has undertaken a pilot study concerning one aspect of organized ambulatory care delivery — hospital satellite clinics.

A list of hospital-sponsored, decentralized ambulatory care sites in southeast Michigan appears in **Table 1.** Currently, there are 26 such sites in the seven counties of southeast Michigan. They have been developed since the mid-1970s, with most of them opening their doors in the last two years of the decade.

Pilot Study participants also are identified in **Table 1.** GDAHC limited participation to those sites operational prior to the commencement of the pilot study.

Pilot Study

GDAHC's pilot study is premised on the assumption that before further research and evaluation can be undertaken, an acceptable, common definition must be articulated. To be meaningful, analyses of ambulatory care must compare "apples with apples."

The overall purpose of the pilot study is to improve our understanding of organized ambulatory care and to provide a framework upon which more comprehensive studies, addressing major ambulatory care policy issues, can be carried out.

Towards this end, the pilot effort is intended to achieve four objectives. They are to:

1. Identify the major financial, operating, social and public policy pressures shaping the delivery of ambulatory care;
2. Develop a working definition of organized ambulatory care that speaks to the major characteristics of the various organizational models.
3. Develop a survey instrument which effectively distinguishes among the various models of organized ambulatory care according to such factors as service program, organizational relationships, physician staffing, patient population, cost and facility ownership.
4. Determine the feasibility of performing more in-depth analyses given existing data capabilities.

The pilot study consists of two major components. First, GDAHC conducted a literature review which addressed the historical development of organized ambulatory care, the forces shaping the growth and operation of organized ambulatory care and the major definitional issues surrounding ambulatory care.

The other major component of the pilot study consists of 12 case studies of decentralized ambulatory care units established by hospitals in southeastern Michigan since 1975. At each site, GDAHC gathered data and information in two ways: a semi-structured, on-site interview and a facility survey.

The first data collection effort consisted of interviews at each participating facility. These interviews were conducted from December, 1980, to March, 1981, by a survey team of GDAHC staff. In informal meetings lasting about three hours, medical directors and administrative managers of the satellites, and administrators and board members of the sponsoring hospitals, responded to a comparable set of questions on the characteristics of the satellites' planning, development and operation.

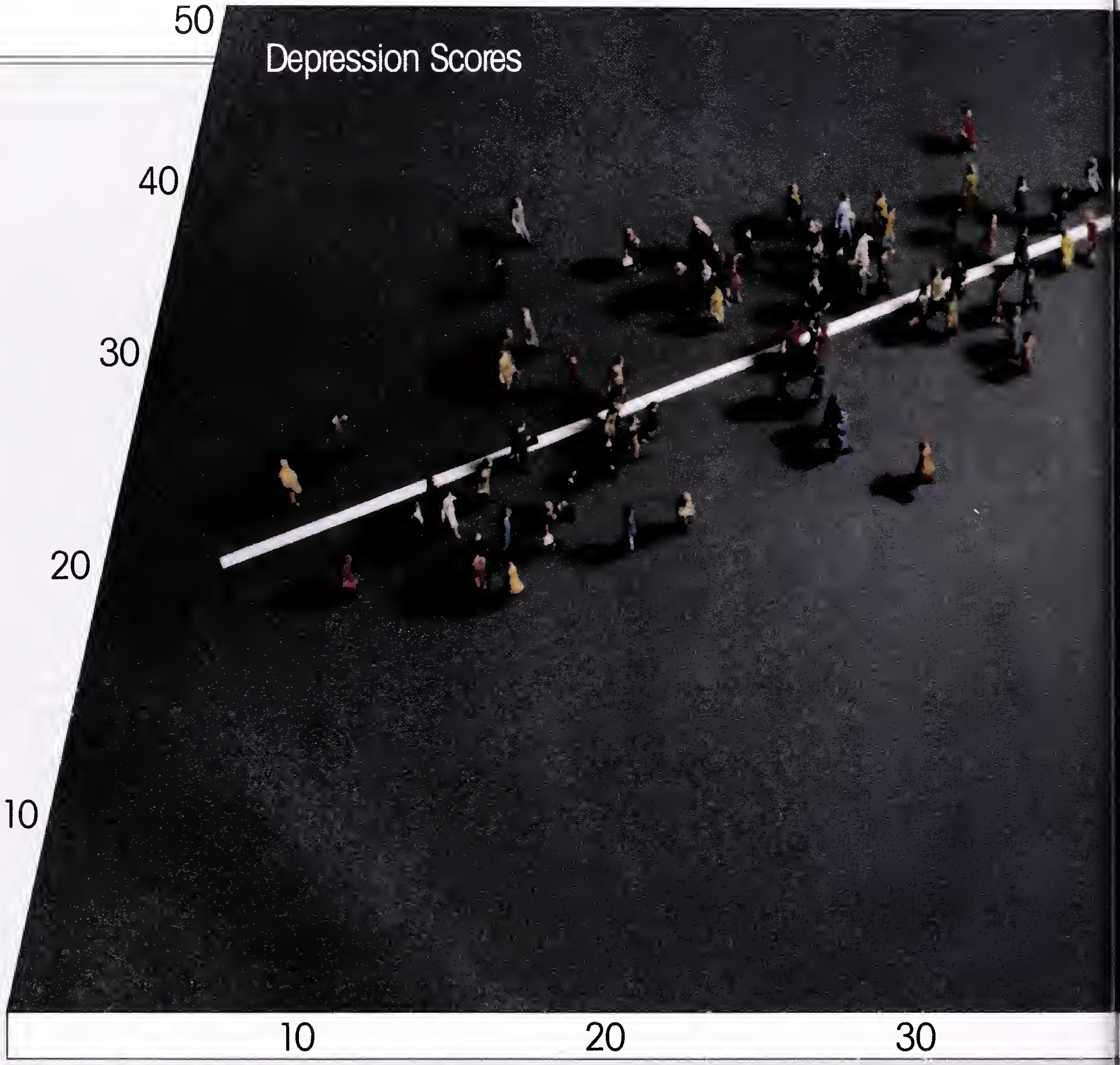
These interviews sought to discover the hospitals' goals in establishing these decentralized ambulatory care sites and those responsible for initiating the discussions which led to their establishment.

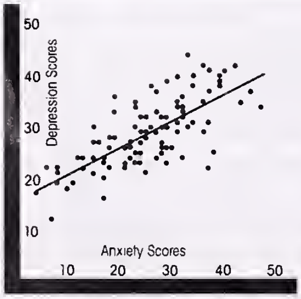
In the interviews, the hospital and satellite representatives outlined the process of planning these facilities and their operations by indicating who directed the process, how long it took and what it entailed. Interview respondents also explained the steps in developing these facilities from the planning stage by noting the process of gathering clinical, community, technical and financial support for the plans.

Lastly, these interviews dealt with some broad discussion of facility operation, such as perceived ad-

Continued on page 76

FOR THE 7 OF 10 NONPSYCHOTIC





Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3] Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

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DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]

Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

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References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35*:1359-1365, 1978. **3.** Clagharn J: The anxiety-depression syndrome. *Psychosomatics 11*:438-441, 1970. **4.** The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137*:1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61*:217-225, 1979.

In moderate depression and anxiety

Limbitrol® CIV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
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Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer–Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50.

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Two concerned MSMS members look at hospital satellite clinics:

Herrington

Toteff

By Kenneth B. Herrington, MD
Bad Axe

As part of the trends of the last 20 years, another change in medical practice is taking place to slowly replace the private practitioner of medicine. This recent change is the development of satellite clinics. To discuss them, I would first like to define what I mean by a satellite clinic.

A satellite clinic is a medical facility, remote from its initiating facility, which provides medical staff, laboratory, and control over the satellite. There are probably many basic types, but two come to mind:

1) A clinic to provide all care to the area of the satellite, with laboratory and inpatient work being referred back to the initial facility.

2) A specialty clinic, i.e. oncology, cardiology, to provide advice to the local physicians in the area, with the probable hope that specialty services required by that patient will be referred back to the initiating institution.

The specialty clinic, of these two, works with a private practitioner and through him provides necessary patient care. The private practitioner can remain in charge of the patient. The doctor-patient relationship is thus maintained. Here the private aspect of practice is traditional, with the satellite clinic acting as a traditional consultant, and the primary care being the responsibility of the referring physician.

A different situation exists with the general clinic. Although local care is available to the patient, the doctor he sees may be primarily

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Doctor Herrington is an internist and a member of the MSMS council.

By Robert J. Toteff, MD
Saginaw

How do I feel about the proliferation of satellite clinics by larger institutions? As a physician educator for 15 years, I can see that hospital satellite clinics can expand the training experience of resident physicians. Thus, they may be a positive step, one of value to a training system.

I have been a full time director of a family practice residency program for seven years, and have become knowledgeable about most of the family practice residency program settings around the state, several of which have expanded to involve satellite settings.

In these instances, the practice profiles differ tremendously. Satellite clinics can allow physicians in a program that might be inner city to gain experience in a rural or suburban setting having different clientele with different medical needs. The reverse also might occur; that is, a community program may satellite to an urban center, which also exposes the resident to a broader base from which to gain expertise.

In other words, it allows learning physicians to have more complete training. It exposes them to different kinds of medical care in a variety of settings, and allows them to make a more informed decision as to the particular setting he is best suited for.

Practicing in a satellite also enables residents to see if their training has been appropriate to enable them to adequately care for patients under different conditions. They may find they need a greater depth of training in specific disciplines to do a more complete job of patient care. It allows them to get first hand knowledge about the level of expertise needed to practice away from the parent institution. As many of these satellites are in underserved areas, they bring residents into contact with a practice when their services are more urgently needed. The often-referred to statistic, "Seventy five percent of physicians will practice within a radius of 75 miles of where they have received some part of their *post graduate* education," may well apply here. Experience in a satellite may well recruit physicians to areas they would not have been exposed to if they trained only in a parent institution. Some satellite clinics also are rotating faculty for staffing purposes, which serves to expose the faculty to different practice settings. It also may serve to upgrade the care being rendered to an area, especially in situations where little or no care had been obtainable prior to the establishment of the satellite.

Another positive aspect is that these satellites usually approach a private practice office setting even when multi-specialty, and afford the resident training in practice management skills not usually obtainable in the large parent institution setting.

I realize that this article makes only positive comments about satellites. There have to be many other differing opinions concerning the merits, or lack thereof, for the beginnings of satellites. However, I will leave those to others to discuss.

Doctor Toteff is director, Saginaw Family Practice Residency Program. March 1, he becomes associate chairman and assistant professor of the Wayne State University Department of Family Medicine.

DOCTOR HERRINGTON/Continued

based many miles away. The rules of the practice are made by a board of directors in a remote, large city and to the primary benefit of the sponsoring institution. The clinic provides more patients, since the person needing care is referred back to the institution. (That same institution itself may have difficulty obtaining patients from its own local area.) In addition, laboratory studies and x-rays are referred back to the primary institution, providng an additional source of revenue.

A large urban hospital, for example, which has been traditionally a referral center, may find previously referred patients are going to a new suburban hospital complete with all specialty facilities. As these newer and more desirably located centers develop, the old center must find new ways to attract patients. A satellite clinic may well be the answer. The original hospital, by developing satellite clinics, increases its drawing area.

This type of clinic of course is not limited to urban and suburban areas. Small rural hospitals may develop a similar type of clinic in outlying communities in order to draw patients who previously have been going elsewhere. These clinics again provide additional patients and increased laboratory work for the sponsoring institution.

When a satellite clinic moves into an area, the private sector faces a real problem in competition. First, with the increased number of doctors serving the area, the doctor ratio is lessened. In addition, however, because of the method of operation of insurance companies, the satellite clinic may be reimbursed a higher amount for a similar procedure than a private practitioner. This is because the hospital is paid on a cost-plus basis and hence fees are not necessarily set. This makes the competition unfair. With this financial inequity and a reduction in a number of his patients, the private practitioner may well be forced to either join or relocate.

This brings about my major concern about the satellite clinics. This is the loss of control over medical practice by physicians. This develops as hospitals of all sizes increase in size, with control slowly centralized into administration. As more programs are set up and run by administration, rules and regulations on all aspects of hospital care become controlled by administrators. The eventual responsibility is then passed on to a lay board of directors. This leaves the doctors in only an advisory position, with little if any actual control within hospitals.

Because of the complexities of running a hospital, this is bound to increase out of necessity. However, hospitals are dependent upon private doctors for patients which is, of course, their only source of income and business. As long as this situation continues the private practitioner can still exert significant control over hospital policies. The patient is *his* patient and hence the basic support of the hospital is in his control. If, on the other hand, the patient is the institution's, the doctor loses control of the institution. Then the doctor is only an important employee, not an independent individual. Thus, through these clinics, administrators and businessmen gain control of medicine. The result the practice of medicine is good for the institution and not necessarily for the patient.

GDAHC SURVEY/Continued

vantages and disadvantages of the operations and others. Participants also completed a short fact sheet concerning the management and administration of these facilities.

The pilot study participants also completed an extensive facility survey which dealt with a comprehensive array of characteristics depicting the facility and its operation. These responses, once pooled, are to give interested individuals a description of hospital-sponsored, decentralized ambulatory care. Consequently, the survey requested information on the number and types of people working there; the utilization of those services by patients; characteristics of those patients; and facility characteristics such as square footage allocation, operating hours, length of time in operation, waiting times and fees.

By May 1981, when these interviews were conducted and the surveys completed, we shared the results at meetings with a panel composed of pilot study participants. GDAHC displayed data in a fashion that permitted review of actual responses without identifying individual facilities.

In the course of these meetings participants identified errors, clarified responses, suggested revised questions and suggested other questions of interest. These suggestions led to a followup questionnaire to more accurately and completely describe the selected characteristics of these satellites; the questionnaire was sent out in September 1981.

We based the pilot study findings upon these interviews and facility surveys conducted between September, 1980 and October, 1981. As of this writing, we have summarized and described the results of the pilot study in a draft report which we will present to the panel of participants for their review and reaction. We will ask committees of the Hospital Council, the Michigan State Medical Society, and other interested parties to comment on the draft report. Based on these discussions, we will finish and revise the report.

With the completion of the pilot study, we will initiate efforts to articulate and pursue relevant follow-up analyses. These efforts will build upon the foundation the pilot study provides.

Ultimately, the feasibility and success of subsequent studies is contingent upon the broad-scale involvement and commitment of participants in all aspects of ambulatory care. GDAHC looks forward to working with other interested individuals and organizations in these efforts.

References are available from the author.

Michigan Medicine plans to publish further articles detailing the results of the Greater Detroit Area Hospital Council survey of hospital satellite clinics, as well as GDAHC follow-up analyses.

How the Michigan Hospital Association views growth of hospital satellites

By Donald P. Potter
Lansing

Since the early 1970s, federal and state government policy and, more recently, private health insurance policy, have been directed toward reducing hospital use to control health care costs. In Michigan, significant activities have been directed toward substituting various forms of ambulatory or outpatient care for services traditionally provided in hospitals.

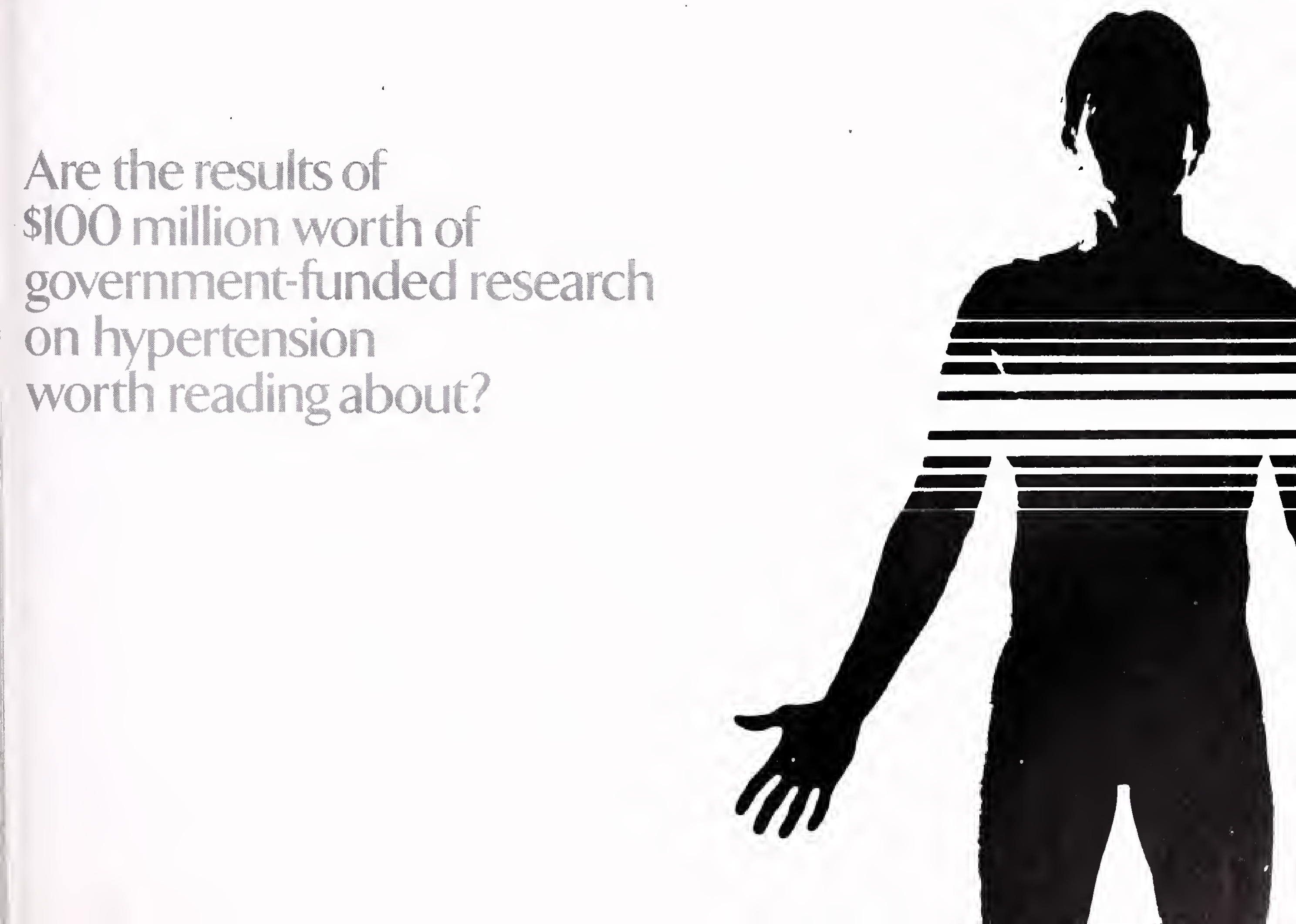
Mr. Potter is director, Department of Health Policy Development, Michigan Hospital Association.

This article will explore the development of organized ambulatory care services with specific emphasis on the hospital role in the delivery of ambulatory services through outreach or satellite clinics.

Background

In recent years, one strategy that has been commonly pursued to control hospital utilization is the supply control strategy. This strategy has resulted in overt efforts to control and, in fact, reduce the supply of hospital beds. The Michigan Hospital Capacity Reduction Program that was initiated in 1979, with a goal of reducing the state's supply of hospital beds by nearly 10 percent, is a clear example of the supply control policy. Since 1979, more than 1,400 hospital beds have been delicensed: an approximate three percent reduction in the hospital bed supply.

It now appears that federal policy is shifting from the supply control direction of the health planning apparatus put in place by federal statute passed in 1974 (P.L. 93-641). This shift has resulted in increasing discussion of demand controls that would be instituted through changes



in third party payors' health benefit programs.

We use the terms "competition" and "consumer choice" commonly today to describe demand controls predicated on market reform as a means of controlling health care costs in general. Hospital officials are not holding their breath in anticipation of some new wizardry that will remove the emphasis on reducing hospital utilization. They are aware, along with other health professionals, that significant rules that govern the allocation of resources to the health care sector may be fundamentally changed in the near future. However, they also are aware that the goal of such changes will not differ from current supply controls — to reduce the use of health care services, particularly acute care hospitals.

A combination of factors, based primarily on increased emphasis by physicians and hospitals, has worked to cause a significant reduction in inpatient utilization in the more recent past in Michigan. A keystone to this trend is the increased substitution of ambulatory care for inpatient care.

The trend toward ambulatory care service development

The Michigan health care delivery system is clearly undergoing fundamental change. Hospitals and physicians alike are part of a noticeable phase of vertical integration, i.e., the formation of group practices and multi-hospital systems to enhance efficiency and generate capital resources needed to realign services in response to changing public expectations and reimbursement incentives.

We are beginning to witness the "unbundling" or partial dismantling, of resources and services that have been the sole property of hospitals. Wherever possible and financially feasible, health care entrepreneurs have been encouraged, in many cases by public policy, to develop and offer services traditionally provided by hospitals. The development of anesthetics that act rapidly with minimal prolonged side effects, the availability of non-narcotic analgesics to treat pain, the changing views of surgeons to encourage patients to become ambulatory soon after surgery, and direct intervention by third party payors all have interacted to produce the phenomenal growth in outpatient surgery we are experiencing today.

We use the term "surgicenter" commonly; and Michigan, as well as other parts of the country, is currently seeing growth in emergicenters, sports medicine orthopedic clinics, outpatient physical therapy clinics, hospice programs and residential substance abuse facilities.

Yet this "unbundling" process is in its infancy.

The obvious result of this process is that the acute care hospital is faced with significant challenges in terms of financial survival and future role. Much like the urban department store that faces major competition from alternative outlets (drug store chains, discount houses, boutiques, specialty shops, mail order houses), hospitals face threats from emerging alternative forms of health care delivery.

Also significant is the growing pressure of the past several years for the hospital to act as a health- rather than illness-oriented enterprise, concentrating resources on more than just curative services. Over time, hospital and health care professionals, along with an increasing portion of the general population, have embarked on a wellness campaign promoting self-determination and individual responsibility toward good health care habits. Such a campaign requires education and frequent screening for purposes of early diagnosis and treatment.

Although definitive data are not available, the trend toward hospitals increasing and/or enlarging their roles in ambulatory care is evident. All Michigan hospitals provide ambulatory care of some form. In 1980, Michigan community hospitals experienced 10,063,372 total outpatient visits with 6,536,271 of those visits classified as other than emergency room visits.

The term "satellite clinic" is generally understood to reference an organized ambulatory care service program owned and operated by a hospital (or group of hospitals), but located geographically separate from the hospital(s) central campus.

While specific data are not routinely collected, one estimate provided by the Michigan Department of Public Health identifies 37 hospitals currently operating one or more satellite clinics. Several hospitals also have developed organized ambulatory care programs in buildings physically separate from, but located on, the hospital campus. The most common form of hospital ambulatory care service, however, is provided within the hospital itself or in an attached building.

Three reasons are commonly provided to explain hospital movement into enlarged ambulatory care programming: 1) to respond to demands for care from patients who continue to use the hospital emergency rooms as a primary care site; 2) to move away from the emphasis on curative medicine and to serve as a true community health care resource; and 3) to expand outreach resources as a means of generating future inpatient utilization.

The growth and development of hospital-owned and sponsored satellite clinics is most pronounced in southeastern Michigan; however, outstate hospitals, large and small, also have begun the development of this form of community service. Outstate, the term "outreach" clinic" often is used to describe the satellite clinic providing primary care in areas where patient access to physicians is recognized as less than adequate.

Organization and structure of satellite clinics

Hospital-sponsored satellite clinics have taken several organizational forms in Michigan. This is expected, as experimentation with this relatively new service program has not yet resulted in a concensus on any best way to organize the service. Essentially, three models have been employed by hospitals or hospital-related organizations in the development of satellite clinics and separately-organized ambulatory care programs:

1. Freestanding facilities owned and operated by hospitals and staffed by physicians employed by the hospital. (Most common in southeast Michigan.)

2. Freestanding facilities owned or leased and administered by hospitals and staffed by privately-practicing physicians who provide fee-

for-service care. (Most common outstate.)

3. Separately incorporated freestanding facilities (either on or off the hospital campus) and staffed by physicians who are employed by the facility. (This model, that operates as a subsidiary of a health care-oriented holding company, while not yet common, appears to be gaining in popularity.)

Hours of operation, breadth of services offered and the use of ancillary health care personnel vary among each of these programs.

MHA's views on hospital satellite clinics

Although the Michigan Hospital Association has no formal position specific to hospital-sponsored satellite clinics, the development and sponsorship of these hospital health care service programs is clearly in keeping with the Association's view of the hospital as the central focus for health care delivery in the community.

Involvement in satellite or outreach clinics is directly related to future survival for some hospitals. If reductions in inpatient utilization are continually realized through the increasing development of alternatives to inpatient care, some hospitals may not be able to fulfill their commitments to their communities unless they are active participants in programs formed from the current hospital service unbundling process.

Also, if the potential patient or consumer is to take a stronger role in determining the future methods of health care delivery, and if health care vouchers become reality, it is even more important that hospital planning and positioning prepare for this potentiality.

Finally, it must be pointed out that the supply of physicians willing to work with hospitals in the development of satellite clinics and other alternative health care delivery programs has not yet reached a saturation point. The rigors, costs and complexities associated with the operation of a modern medical practice appear to be significant when compared with contractual arrangements that provide for more professionally-acceptable medical practice and lifestyles.

Reimbursement for services provided by satellite clinics

Reimbursement for services provided by hospital-sponsored satellite clinics varies with organizational form. Clearly, those patients who have no third party coverage are served as fee-for-service patients whether the facility or the physician does the billing. Direct billing is, of course, the highest risk form of service reimbursement and uncollectable debts are not uncommon.

Third party payment for services provided by satellite clinics is relatively complex. However, a general overview of reimbursement for the organizational forms previously described follows:

1. Freestanding facilities owned or leased and operated by hospitals and staffed by physicians employed (or staffed by private practicing physicians) by the hospital.

A number of methods are used by third party payors to reimburse for services rendered by these forms of

In 1977, when the Veterans Administration compared Step-2 regimens in 450 mild hypertensive patients, which regimen was proven most effective?[1]

clinics and the methods vary among Blue Cross and Blue Shield of Michigan, Medicare and Medicaid. Most frequently used is a cost-related reimbursement system for facility costs with the professional component billed separately.

The cost-related reimbursement system, however, is applicable only to covered benefits. Moreover, there are a number of exceptions to this basic reimbursement arrangement. For example, Blue Cross and Blue Shield of Michigan does not allow hospitals to charge a "professional" fee for such services as pathology and anesthesiology.

The rules of cost reimbursement force an over-allocation of overhead costs and other indirectly related costs to satellite clinics. For example, many costs such as laundry, medical library, medical records, utilization review and general business office tend to be disproportionately allocated to satellite units. This is a major problem for hospitals.

2. Separately-incorporated freestanding facilities staffed by salaried physicians.

These facilities are reimbursed by third parties on a fee-for-service basis with fees limited to prevailing charge screens. This form of reimbursement is exactly the same as that under which private physicians operate.

Many people misunderstand hospital reimbursement for services provided in satellite clinics. Physicians, in particular, have raised concerns relative to unfair competition. Three specific concerns worthy of discussion follow:

1. Hospitals are reimbursed a facility fee in addition to the fee-for-service.

This apparent inequity is recognized by hospitals and third party payors. So long as hospitals are required to allocate overall hospital costs in a manner that distributes portions of hospital overhead costs to satellite clinics owned and operated by hospitals, it is only fair that hospitals be reimbursed for those costs. This inequity will exist so long as clinic services are required to absorb a portion of hospital overhead or until physician reimbursement is revised to include overhead facility costs. The separately-incorporated clinics that operate as subsidiaries of health care holding companies are the only current clinics that are freed from having to distribute hospital overhead in cost allocation activities.

Significant, however, is recent Congressional action that addresses this inequity. Section 934 of TITLE IX of the Omnibus Reconciliation Act of 1980 (P.L. 96-499) addresses the Medicare and Medicaid reimbursement provisions for ambulatory surgery. For surgical procedures that can be performed in a physician's office, an amount calculated to take into account any overhead expense not usually incorporated into the professional fee for equipment, supplies and space would be established and paid in full.

2. Hospitals are able to build these clinics with tax-exempt financing.

It is true that hospitals are able, through the Michigan Hospital Finance Authority, to use tax-exempt revenue bonding as a method for obtaining the capital to build satellite clinics. Hospitals also are required to obtain certificates of need from the Michigan Department of Public Health, after review by the local Health Systems Agency, to attest to the need for such facilities prior to obtaining any funds through the Finance Authority. Privately-practicing physicians are not required to undergo this intensive scrutiny except where such endeavors fall under the certificate of need statutory requirements that organized ambulatory health care facility and freestanding surgical outpatient facility programs be reviewed and approved. It should also be understood that physicians and hospitals alike have an opportunity to use local Economic Development Corporation bonds to obtain tax-exempt bond funds as a capital resource.

3. Hospitals are non-profit corporations exempt from income tax revenues derived from satellite clinic operations.

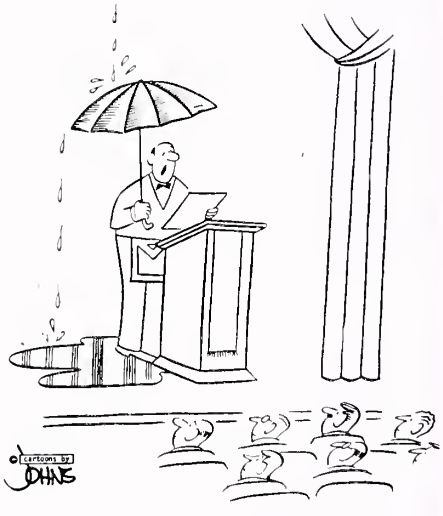
It also is true that hospitals, as not-for-profit corporations, are generally granted tax exempt status and thus are not required to pay income taxes on revenues generated from clinic operations. Physicians employed by the hospital to staff a clinic, of course, are required to pay personal income taxes on their salaries. But no corporate income tax is paid on hospital revenues. Freestanding facilities incorporated under organization form #3 (above) may be incorporated as not-for-profit or for-profit corporations and thus may be required to pay corporate income taxes on profits if organized on a for-profit basis.

While the corporate tax exemptions for hospitals may seem inequitable as they relate to private corporations formed by physician practices, it should be noted that nothing precludes physicians from forming not-for-profit corporations for group practices, thereby enjoying the same rights as hospitals. This, however, would require that the corporation be formed following the Internal Revenue Service requirements for nonprofit corporations in order to receive tax-exempt status, i.e., that the corporation must express and meet the goals of a charitable organization.

Summary

The "unbundling" of hospital services, and hospital diversification to provide health care services apart from inpatient curative services, are two related trends that likely will increase. Although changes in the delivery of health care services have consistently taken place in modern times as new knowledge has been gained respecting the physical, mental and social well-being of mankind, never before has change come so rapidly in the way health services are delivered to the citizens of Michigan and the nation. Working together, wherever possible, to oversee and accomplish the significant changes that are clearly on the horizon is an important means by which hospitals, physicians and other health care professionals can assure that these changes serve the public interest.

(References are available from the author.)



". . . *However, first we must take up more urgent MSMS business.*"

Henry Ford Hospital forerunner in state trend to ambulatory care

From the Public Relations Department
Henry Ford Hospital, Detroit

In the 1960's Henry Ford Hospital realized the traditional role of the hospital had to change to meet new lifestyles and health care needs, the movement of the people out of the city, the needs of an aging population, and the ever-changing medical technology.

The way that was chosen to do this was to open "branches" linking the Detroit-based hospital and specialty clinics to additional urban and suburban areas where the hospital's high standards of health care would be readily accessible to the people right in their own neighborhoods.

Henry Ford Hospital was among the forerunners in ambulatory care in Michigan, opening its first suburban "satellite" center in 1974 in Troy. Other larger centers were opened in 1975, and two more were added to the system in 1980. More than 100 full-time physicians and dentists maintain their practices in the suburban ambulatory care centers. In 1981 the satellites had a combined total of 459,000 outpatient visits.

The satellite centers are located in communities throughout the metropolitan Detroit area and offer services as follows:

- **Henry Ford Hospital Fairlane Center, Dearborn,** provides a broad range of adult and pediatric care services, 24-hour emergency care, ambulatory surgery, hemodialysis, lab and x-ray services.
- **Henry Ford Hospital West Bloomfield Center** is almost identical in concept to the Fairlane Center. It provides adult and pediatric care, 24-hour emergency care. ambulatory surgery, lab and x-ray services.
- **Henry Ford Hospital Sterling Heights Center.** Provides many of the same services as the Fairlane and West Bloomfield centers including 24-hour emergency care.
- **Henry Ford Hospital Lakeside Center,** also in Sterling Heights, has limited primary care services.
- **Henry Ford Hospital Troy Center** provides hemodialysis and counseling services and houses the Hospital's computer and business operations.

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), which Step-2 regimen was preferred and was deemed effective without significant adverse effects?[2]

MD-owned liability insurance firms facing critical period to their survival

From the AMA, Chicago

“1981 nation-wide facts clearly indicate that the honeymoon is over for the physician-owned companies writing medical liability insurance. And the long tail on claims has arrived.” That was the message of James Sammons, MD, executive vice president, American Medical Association, who spoke at a recent Forum for Medical Affairs program in Las Vegas.

Although the frequency and severity of claims are increasing at an alarming rate, Doctor Sammons urged the continued support of physician-owned companies, because “they will be there when you need them.” Doctor Sammons said that 45 percent of the national market is covered by physician-owned companies, and the American Medical Association Insurance Company is providing reinsurance for 45,000 physicians in the US today.

California, New York

Brad Cohn, MD, president, California Medical Association, stated that California is experiencing a repeat of the 1974-75 crisis and doesn’t see it changing. He blames this trend on the liberal courts in California, higher limits on claims, and higher costs for medical liability insurance. In talking about the liberal court systems, Doctor Cohn cited a recent court case in which it was decided that a physician must explain all risks if the patient refuses to submit to tests and then must be able to prove that he explained those risks to the patient if a claim results.

Arthur Mannix, MD, president, Medical Liability Mutual Insurance Company, echoed the remarks of Doctor Cohn by stating that New York has been in a continuing crisis since 1973, with no relief in sight. One of the problems he sees with the increasing cost of medical liability insurance is that physicians can no longer pass the cost on to the patient. “We are looking at a fixed fee market whether we like it or not,” he said.

Brighter situations

The story from Indiana and New Jersey was much brighter. Gilbert M. Wilhelmus, MD, past president of the Indiana State Medical Association and a member of Indiana’s Legislative Medical Malpractice Study Committee, said the number of claims being filed in Indiana today is the same as two and a half years ago. He said the premium for medical liability insurance has been stable since the passage of the Patient’s Compensation Act in 1975, and there is no problem obtaining coverage.

Bernard H. Genest, vice president for claims administration, New Jersey State Medical Underwriters, Inc., said there is no evidence there has been an increase in severity in New Jersey in the past five years. He

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MPMLC in good shape

The Michigan Physicians Mutual Liability Company, founded in 1976 by MSMS to answer the malpractice insurance crisis of that time, is in good shape, says President Robert M. Leitch, MD, Battle Creek.

According to the highly-respected insurance journal, *Best’s Review*, MPMLC became the foremost Michigan writer of professional liability insurance with its 1980 total of $17,253,000 in premiums written. This gave MPMLC 23.1 percent of the state’s market, and represented a 22 percent increase from 1979, when the Michigan physician-owned and -operated company was the second largest carrier.

MPMLC ranks 23rd in size among the writers of this type of insurance in the nation.

Through mid-1981, the trend was toward an upsurge in claims to MPMLC. Mounting losses and adjustment expenses to the company were offset by significant investment income.

Premiums written by MPMLC as of Sept. 30 totaled $14,264,626. Total assets were listed at $78,340,535. Also in 1981, MPMLC added 748 physicians to their rapidly growing number of insureds, and the company’s new lines of coverage (umbrella, excess, building and office package) and increased limits are proving to be extremely popular.

MPMLC’s year-end, audited financial figures were being accumulated in January. They will be available to all policyholders in the company’s 1981 Annual Report which will be published this spring.

felt this was partially attributable to the short time it takes to close a claim in New Jersey — 9.6 months — as opposed to the national average of 37 to 46 months.

Mr. Genest stated the interest on reserves is not keeping up with medical liability inflation which is running at 30 percent, and this could create a problem for physician-owned companies in the future if management doesn't take action now.

In talking about the viability of physician-owned companies, Vernon B. Astler, MD, chairman of the Board of the Florida Physicians Insurance Reciprocal, pointed out the need for loss control programs. He said the Florida company held six loss control seminars in 1980 which were attended by 600 of their policyholders. The benefits derived from those seminars have been: less claims filed against those physicians who attended; and those physicians who attended, but have been sued, have been far more defensible than those physicians sued who haven't attended. They increased the number of seminars to 37 in 1981 and have now reached more than 7,000 of their insureds. Two of these seminars were videotaped and will be made available to other states upon request.

In looking at some of the facts gathered through risk management, William D. Robertson, MD, chairman, Risk Management Committee for the Washington State Medical Society, said that he believes you can improve the quality of medical care, reduce the risk to patient and physician, and control cost of premium and settlement if the program is set up properly. He feels that such a committee needs to look at the trends in malpractice claims — to see whether they are preventable — and the process for early detection and avoidance.

Doctor Robertson said WSMA records show that where adequate records are kept by a physician there is no payout in 64.5 percent of the claims. However, when inadequate records are kept, 61.5 percent result in paid claims.

The same is true for reporting a suspected claim. For a suspected claim reported in less than a year, the mean cost for settling is $21,000. If it is not reported until three years or more, the cost for settling that same claim is $65,000. In claims closed prior to 1980, informed consent was a problem in 21 percent of the claims. Informed consent has become a problem in 31 percent of the claims opened in 1980-81, Doctor Robertson said.

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, **which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?**[3]

NEWSFRONTS

Plastic surgeons performed more operations for hand trauma and reconstructive hand surgery than any other corrective plastic surgical procedure this past year. Between mid-1980 and mid-1981, 150,000 hand surgeries were done.

Breast augmentation (enlargement) was the most frequently performed aesthetic procedure. During the same reporting period, 72,000 breast augmentations were completed.

These findings come from a new survey of its members by the American Society of Plastic and Reconstructive Surgeons (ASPRS). Some 1600 — or 61.5% — of the Society's 2,600 worldwide members participated in the survey.

Since the beginning of this year's Reye's Syndrome (RS) season Oct. 1, nine cases of RS were reported.

There was one death among the nine cases; a 12½ month old female infant from Ingham County presenting at stage III. At autopsy, parainfluenza 3 virus was isolated from the nasopharyngeal aspirate and cytomegalovirus from the liver of this child.

No one is making any firm predictions yet as to the type or amount of influenza we'll see this winter, according to William Hall, MD, Chief of Disease Surveillance, Michigan Department of Public Health. However, no strains appreciably different from those seen in previous years are expected to appear.

Two isolates of type B influenza virus similar to the B Singapore Strain that circulated two years ago were obtained from residents of Houston, Texas who were ill in early November.

It seems likely that some type B influenza virus will circulate this year, although in the past when type B virus has returned after only a one year absence we've had a mild B year. The type B influenza virus infections are more commonly followed by RS than are infections with type A influenza viruses.

One isolate of type A (H1N1) virus, a minor variant of the A Brazil strain that circulated last year has been obtained from a New Jersey resident. No influenza virus isolates have been obtained to date from elsewhere in the US, including Michigan.

Two University of Michigan scientists report that tests of a new filter for artificial kidney machines show it may cut in half the hepatitis risk for hemodialysis patients.

Some 50,000 patients in the United States require kidney machine hemodialysis one to three times a week in order to survive.

Doctors have established that

Believe it or not, doctor,
it's the combination found in...

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(hydroflumethiazide 50 mg/
reserpine 0.125 mg)

And don't the results of more than
$100 million worth of clinical trials,
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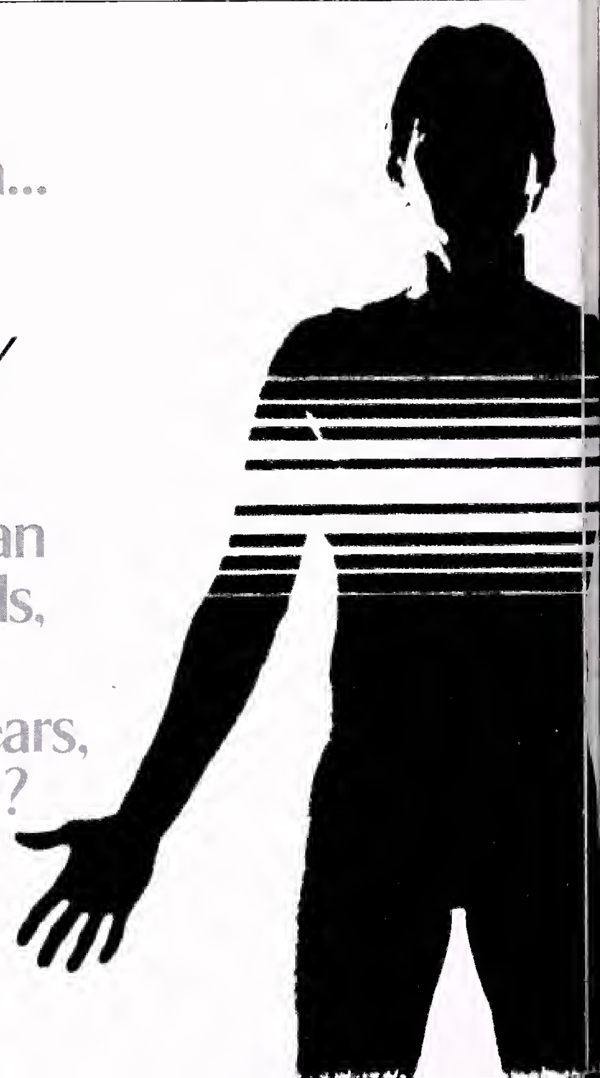
who were followed for several years,
merit your serious consideration?



about half of the hepatitis contracted by kidney machine patients comes unavoidably from the frequent blood transfusions they require. The other 50 percent comes from previously infected patients through a dialysis equipment gauge contaminated by tiny viruses that survive despite elaborate cleansing procedures.

Using equipment designed to simulate the standard hemodialysis apparatus Doctor Port and Doctor Bernstein determined that the new hydrophobic filter prevents viruses from reaching the monitoring system. The particular filter tested by Port and Bernstein was developed by the Medical Device Division of Gelman Sciences, Inc., of Ann Arbor. It is effective as a barrier to both aqueous solutions and to aerosols, allowing only sterile air to pass.

Study suggests too many patients admitted for intensive care — William A. Knaus, MD, George Washington University Medical Center in Washington, DC reports that nearly half the patients admitted to his hospital's ICU over an eight-month period actually did not need intensive treatment.

Instead, these patients mainly needed close nursing attention with the emphasis on observation.

And this, Doctor Knaus suggests, could have been accomplished elsewhere in the hospital rather than in the costly ICU.

The implication of this study, if the same pattern holds true nationally, is that admissions to ICUs conceivably could be cut back without jeopardizing patient care. This in turn, would slow the demand for more ICU beds, which have been increasing at about four percent a year.

In 1960, only 10 percent of U.S. hospitals with more than 200 beds had ICUs. Now 99 percent of these hospitals have such facilities, and it is estimated that some 42,000 patients a day are in intensive care units.

Traditionally, Doctor Knaus said, it has been assumed that these patients require "a costly level of therapeutic intervention and have a high in-hospital mortality."

He and his colleagues, who conducted the study on 624 consecutive admissions to the ICU, found a far different situation. About half of the patients admitted were not in any immediate danger; in other words, their vital signs were stable, and they received only minimal amounts of active treatment.

Other students, Doctor Knaus pointed out, have shown that for every patient admitted to the ICU not needing intensive treatment, an experienced ICU nurse is being underutilized.

A T-lymphocyte-selective immunosuppressive drug with demonstrated ability to lower rejection rates in renal transplantation procedures is being introduced in the US, following licensing by the Bureau of Biologics of the Food and Drug Administration.

In clinical trials, ATGAM sterile solution increased the one-year survival rate for kidneys transplanted into patients by as much as 27 percent.

And there's more proof on the way!

1982 will see the completion of the Multiple Risk Factor Intervention Trial (MRFIT)—a six-year, 12,000-patient study assessing the factors that increase risk of cardiovascular disease. For the management of hypertension, the preferred Step-2 regimen in this study is reserpine-thiazide.

In 1978, in a preliminary report presented to the Epidemiology Section of the American Heart Association (Dallas, Nov 1978), after 12 months of the trial, fewer patients (5.3%) treated with reserpine suffered depression than even the untreated control group (7.7%)!

Please see references and brief summary of prescribing information on last pages of this advertisement.

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SM-2348 11/81

1981 — the medical year in review

There have been a number of significant accomplishments in medicine over the past year, all of which rest on sound experimental research and years of investigation, according to James H. Sammons, MD, executive vice president of the American Medical Association. Among the most exciting developments — which have advanced the course of medicine — one would have to include:

- **PET Scanner** — Spawned from the CAT scanner, this second generation medical technology (PET: Positron emission tomography) allows us to witness for the first time whether or not actual cells are working as they are supposed to.
- **Hepatitis B Vaccine** — The first entirely new viral vaccine to be approved in ten years, this will be the first line of protection against a virus that infects as many as 300,000 Americans a year.
- **Lytic Enzyme Therapy** — This still highly experimental treatment shows tremendous promise for preserving the heart muscle from further damage following a heart attack, or possibly even nipping a heart attack in the bud, so to speak, by dissolving the clotted material where it clogs a coronary artery.
- **Hybridoma Technology** — This technology has made possible the production of monoclonal antibodies, which can be thought of as akin to the targeted weapons of our immunological defenses. The advent of this technology has opened up new vistas in cancer detection and disease therapy, as well as added to our general understanding of the body's immune system.

Salutensin® Salutensin-Demi™

(Hydroflumethiazide, Reserpine Antihypertensive Formulation)

Brief Summary of Prescribing Information (12) 10/27/78

For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

- **Microsurgery** — Techniques to join blood vessels continue to expand, now into the brain.
- **Electrical Stimulation to Promote Bone Healing** — Using electromagnetic forces, physicians in a number of medical centers have achieved bone healing at a rate comparable to that of bone-graft operations, with considerably less risk to the patient.
- **In-Utero Surgery** — This year saw pioneering fetal surgery, the bold extension of the surgeon's skills into the womb for the treatment and correction of a number of disorders that threaten unborn babies.
- **Calcium Antagonists** — A new direction for the treatment of certain heart beat irregularities and angina by drugs that influence calcium metabolism at the cellular level.
- **Beta-Lactams** — These new, third generation antibiotics (penicillins were the first generation of beta-lactam antibiotics) have a wide spectrum of activity against gram-negative bacterial infections.
- **Beta-Blockers** — This new line of drugs has sharply reduced the death rate among heart attack victims by significantly protecting against the recurrence of an attack.

Looking forward to the new year, organized medicine is committed to help develop effective health care mechanisms at the local level as the federal government begins to cut back on funds for providing health care. The American Medical Association is determined to make health care more cost-effective while preserving its quality and its availability.

ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine

Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

1 tablet b.i.d.

SUPPLIED

Bottles of 100 and 1000 scored 50 mg. tablets.

References:

1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

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Report B of the AMA Council on Scientific Affairs

Genetic counseling and prevention of birth defects

A series of reports on scientific subjects was a highlight of the Dec. 6-9 Interim Meeting of the AMA House of Delegates in Las Vegas.

In adopting the reports from the AMA's Council on Scientific Affairs, the House called for:

- **The AMA to advise the federal government that adequate genetic counseling must be incorporated into any prenatal screening program, to encourage specialty societies to enhance their efforts to train physicians in the newer techniques of antenatal diagnosis, and to advise Congress that the National Genetic Disease Act should be renewed and expanded.**
- **Research in the development of new psychosocial models of depression, studies to identify more accurate diagnostic criteria for anxiety and depression so that more uniform prescribing may follow, and studies on the clinical course and morbidity of individuals with untreated anxiety and depression.**
- **Physicians to advise their patients that studies of the safety and efficacy of dimethyl sulfoxide (DMSO) are progressing and cautioned physicians not to displace conventional therapy.**
- **Use of estrogen during menopause only for responsive indications, in the smallest effective dose, and for the shortest period that satisfies therapeutic need.**
- **Support for continued studies of persons exposed, or allegedly exposed, to Agent Orange and its associated contaminant TCDD, and for physicians to be alerted through AMA publications to the signs of chloracne and possible signs and adverse effects of TCDD exposure.**

In the next few issues, *Michigan Medicine* will present the full reports on each of the subjects listed above, for Michigan physicians' fuller knowledge.

We begin with the report on genetic counseling and prevention of birth defects, which also happens to be the subject of the 1982 Michigan Conference on Maternal and Perinatal Health April 14-15 in Grand Rapids. (Details on that conference appear on the inside front cover of this magazine.)

Health statistics from the wealthier countries, including the US, show that congenital disease has become the major cause of infant mortality, accounting for 25 to 35 percent of all infant deaths.

The advances in the science of genetics and genetic screening programs have brought an explosive expansion of prenatal screening techniques and of genetic counseling services.

This has been accompanied by some regional disparities in available services and some differences in philosophy concerning such programs. Furthermore, even greater distortions may be anticipated should screening programs, as exemplified by the alpha-fetoprotein proposal of the Federal Food and Drug Administration, Bureau of Medical Devices, be authorized on a national scale or should recombinant DNA techniques (genetic engineering) attain the envisioned capacity to correct the missing or defective genes.

For these reasons, the AMA Council on Scientific Affairs felt it desirable to review the state-of-the-art of genetic screening and counseling as practiced today.

Description

Genetic counseling involves advising a family on the human problems that may arise from "the occurrence," or "risk of occurrence, of a genetic disorder in a family." The concerned family members must be advised of the medical facts; the severity and prognosis of the genetic disorder, the risk of its recurrence, options available for managing the defective family member and for avoiding recurrence. Often the options chosen by the husband and wife will depend on social, ethical and religious issues as well as the medical estimate of the burden of the disorder, its impact on the affected individual and the family.

Usually, the need for counseling is recognized by the pediatrician, the obstetrician or other primary care physician after the delivery of a defective child. This can be unfortunate, because the urgent and unexpected nature of the situation arouses feelings of guilt, anxiety or anger in the parents and sometimes even in the physician.

Although prospective counseling is to be preferred, and many of the current advances in antenatal diagnosis are aimed at early detection, there will always by unanticipated genetic defects that appear after delivery and some that cannot be recognized until middle life (such as Huntington's disease).

Much effort will continue to be directed towards identifying groups of people who may be at high risk of delivering an infant with a birth defect.

Prospective counseling should be directed at high risk couples who may be able to avoid delivery of a defective infant through appropriate strategies. Such indications for referral to a genetic counseling center include:

- Genetic or congenital anomaly in a family member;
- Family history of an inherited disorder;
- Abnormal somatic or behavioral development in a child;
- Mental retardation of unknown etiology in a previous child;
- Pregnancy in an older (>35 years) woman;
- Specific ethnic background

Continued on page 93

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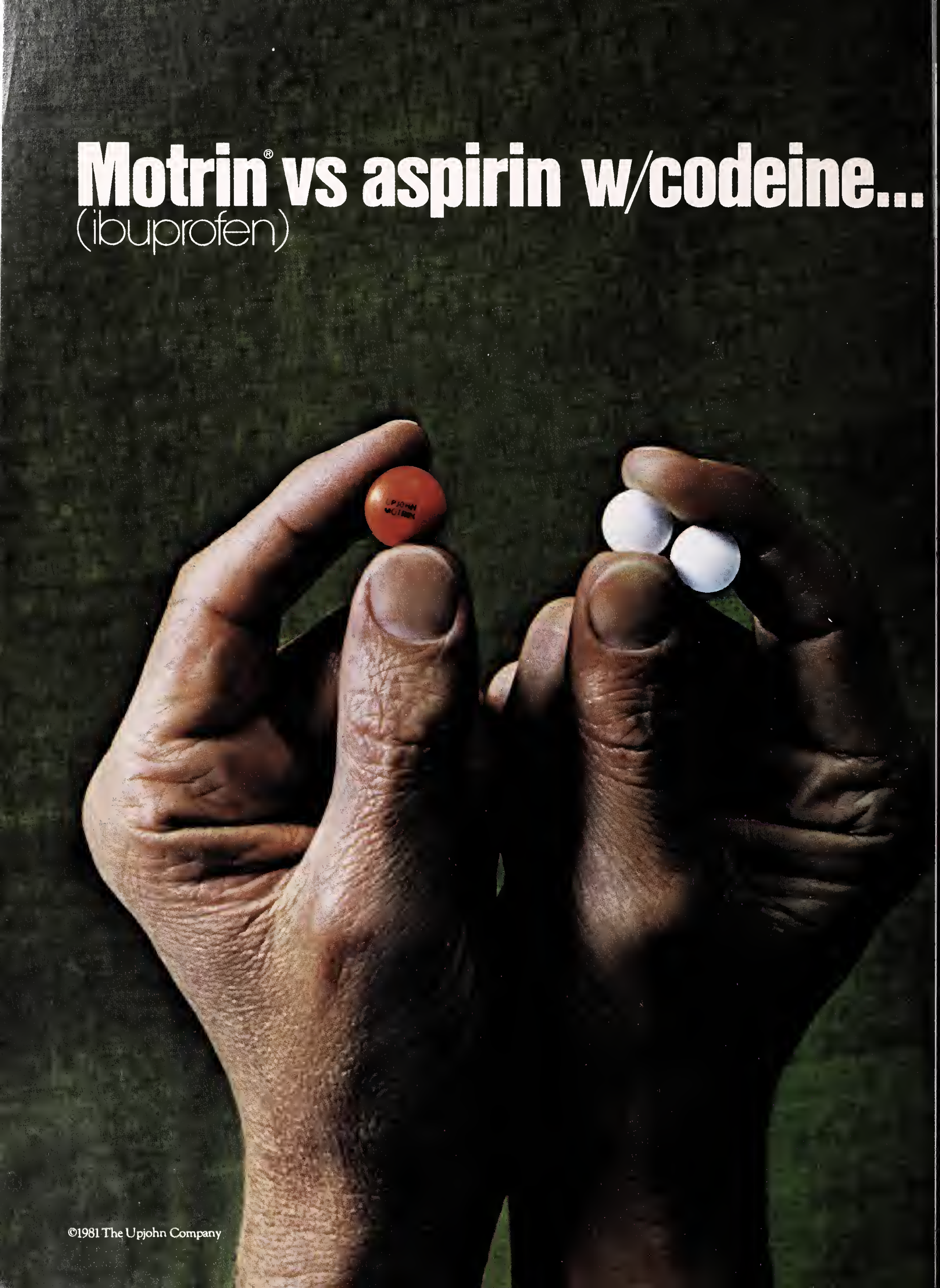
Motrin® vs aspirin w/codeine...
(ibuprofen)
UPJOHN
MOTRIN

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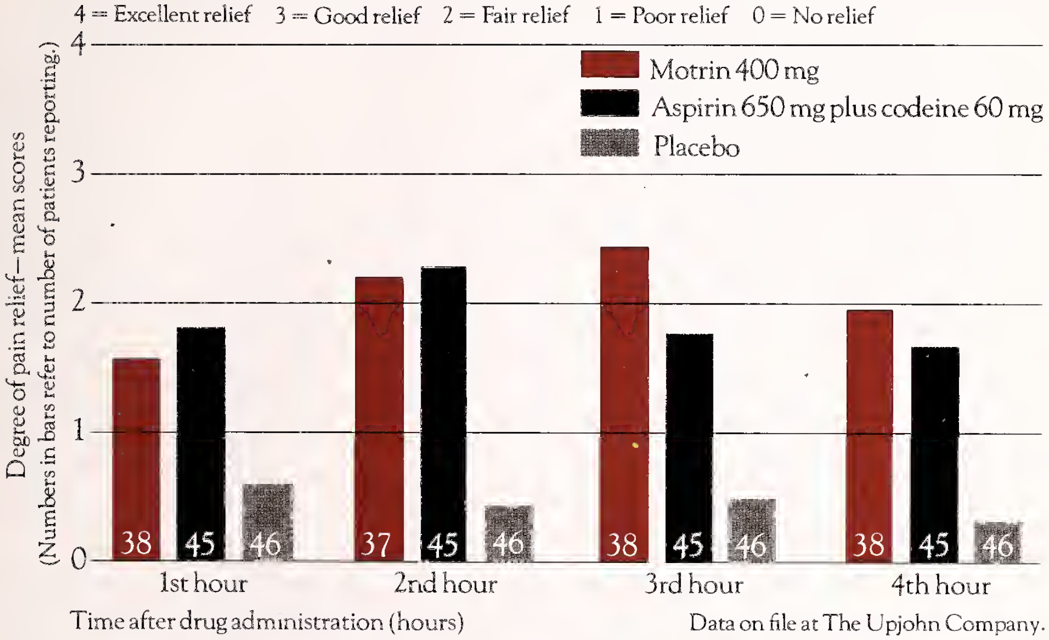
compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination



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For relief of mild to moderate pain:

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• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

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Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin.* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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that may suggest a high rate of genetic abnormality;

- Drug use or chronic exposure to possible teratogens or mutagens;
- Three or more spontaneous abortions and/or early infant deaths;
- Infertility.

Frequency of birth defects

McKusick has recently catalogued 736 inherited defects that are definitely transmitted by autosomal dominant inheritance and a similar number that have been suspected of being inherited in this way. He has labelled 521 conditions known to be definitely transmitted as autosomal recessive characteristics and 596 more in which this possibility may exist. There are 107 definite and 98 suspected recessive disorders that are X-linked, so that the abnormality is manifested only in sons of carrier mothers. There are many other disorders that are probably multifactorial in origin, but may yet have a strong hereditary component, such as hypertension, schizophrenia, diabetes mellitus, asthma and peptic ulcer.

The tremendous burden to individual families and to society that results from the birth of a retarded child hardly needs to be emphasized. The prevention of this event is one of the principal goals of antenatal screening.

The most common birth defects which can lead to mental retardation and yet that may be susceptible to early prenatal screening in appropriate groups with selective interruption of pregnancy, include:

- Down's syndrome (mongolism) and other aneuploidies in older women;
- Neural tube defects in affected families;
- Tay-Sachs disease in Ashkenazi Jews.

In addition, neonatal screening tests for phenylketonuria and congenital hypothyroidism have become mandatory in many states, because the tests are so simple and the reward of finding a case in infancy so great.

Premarital screening for heterozygote sickle cell disease in blacks and for thalassemia in people of Mediterranean descent have been suggested so that couples might know the risk they run of delivering infants that are homozygous for the abnormality and will carry a life-long anemia.[1] Also, it appears that a screening test for carriers of the cystic fibrosis gene may soon be possible.

Another obvious goal in newborn screening programs would be to identify those defects which might be managed by appropriate dietary regimens. The classic example of this is, of course, phenylketonuria which is managed by a phenylalanine restricted diet.

However, there are many rather rare genetic defects which lead to accumulation of incompletely metabolized compounds (hypertriglyceridemia, homocystinuria, histidinemia, branched chain ketonuria, galactosemia and phytanic acid storage disease) and which have responded, sometimes quite well, to dietary restrictions of the critical metabolic substrate.

The rarity of these conditions might suggest that an elaborate screening program is unwarranted; however, several states have mounted simple blood and/or urine screening tests that are inexpensive and able to detect several abnormalities on a single sample from an infant.

Heterozygote recognition

Carriers of autosomal recessive genes are usually healthy and recognized only with the delivery of their homozygous infant. However, the recognition of the heterozygous state before conception may allow the best chance for prevention of defective infants. The one successful example of screening for carriers of a serious heterozygous state has been the effort to identify carriers of Tay-Sachs disease (amaurotic familial idiocy, or the G_{M2} gangliosidosis).

Married non-pregnant couples of Ashkenazi-Jewish extraction were sought through an extensive promotional campaign in Baltimore. Subnormal levels of hexosaminidase A in serum of the screenees were used to identify the heterozygote individuals from the high risk population, who were then advised of the finding. This attempt at diagnosis prior to conception was well received and the program was considered a success, some parents choosing to avoid the birth of affected children.

By contrast, efforts to detect carriers for thalassemia in a small Greek community and, later, for sickle cell disease in several American Black communities, were met with resentment, because the identified heterozygote carriers felt stigmatized. They felt the program to be an invasion of privacy, an infringement on their freedom, and perhaps a display of racism. Furthermore, they had trouble understanding the need for uncovering the disorder, when no treatment was known. Finally, the Black Americans were approached with hastily constructed programs inspired by political pressure which manifested little attention to genetic counseling, record-keeping and adequate follow-up. Many physicians still feel, however, that such screening done properly is worthwhile.

Prenatal diagnosis

Once a genetically defective fetus has been discovered in the second trimester, the decision to interrupt the pregnancy will depend upon the couple's attitude toward abortion, the seriousness of the defect, and adequacy of their understanding of the affected infant's prognosis.

A maternal serum test may indicate elevated levels of alpha-fetoprotein in pregnant women carrying a fetus with an open neural tube defect (NTD). The problems and issues surrounding this test have been discussed in a previous Council Report which recommended against routine use of this test. It did, however, suggest that high risk mothers de-

Continued on page 96

Candidates for nutritional therapy...

10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socioeconomic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]

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Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.
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Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
Adverse Reactions: Adverse reactions have been reported with specific vitamins and

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5,000,000 hospital patients with infections.[4] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[3]

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.[5]

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.
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served other efforts at prenatal NTD diagnosis.

The predictability of any given screening test depends upon the sensitivity and specificity of the test and also upon the frequency of the abnormal condition in the population being studied.

Thus, for a condition as rare as most genetic defects are, a screening test must have very high sensitivity and specificity, if it is to have any predictive value at all.

Furthermore, of that large number of conditions that can result from genetic abnormality, only a few can be recognized before delivery, and fewer still can be anticipated before conception. In those patients where a prenatal diagnosis is made, the parent must be advised in most instances that there will be no known treatment for the abnormal infant: the only alternatives are therapeutic abortion or continuing the pregnancy in the knowledge that they must care for the affected child.

Amniocentesis at 15-16 weeks gestation allows for the alphafetoprotein and perhaps other chemical entities that may be specifically elevated in certain known defects (eg, acetyl choline esterase for neural tube defects), but fetal cells are retrieved for culture fibroblasts which may then be examined for biochemical abnormalities and for chromosomal defects.

Primary cells found in the amniotic fluid are not useful. Karyotyping and sex determination of the cultured fetal cells in the appropriate phase of cell division must then be done by employing various techniques of chromosome banding and chromosomal analysis.

Sophisticated biochemical studies on these cells, cultured a little longer, may also provide prenatal recognition of biochemical errors in metabolism; although this type of study is not yet amenable to general screening, it should probably be available to those families at high risk. Such testing in competent hands allows the recognition of certain lipoidosis, mucopolysaccharidosis, carbohydrate disorders (eg, galactosemia), amino acid (eg, maple syrup urine disease) disorders, and such miscellaneous deficiencies as acid phosphatase, 1,4 glucosidase or hypoxanthineguanine phosphoribosyl transferase (Lesch-Nyhan syndrome) deficiencies.

Thus, when cytogenetic and biochemical tests on cells are added to direct biochemical tests of the amniotic fluid, it is apparent that a considerable amount of information could become available from midtrimester amniocentesis.

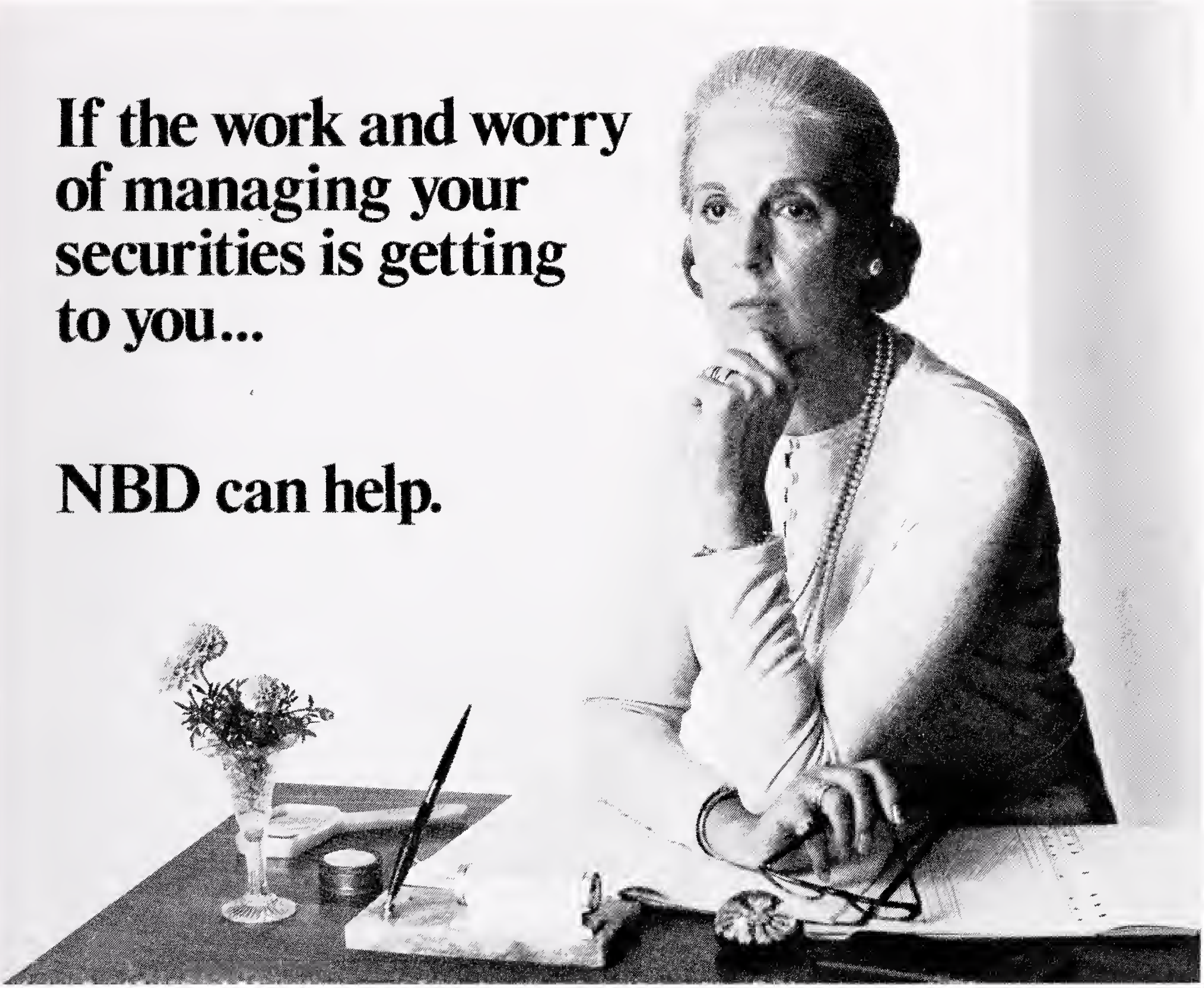
Amniocentesis is not completely without hazard; earlier series had shown an unexpected fetal loss (abortion) in 0.5 percent to 1.5 percent and higher. A recent national collaborative study has reported no significant fetal wastage in 1,040 women undergoing amniocentesis, even though immediate vaginal bleeding and amniotic fluid leaks were not rare. Currently, in screening for Down's syndrome, a maternal age above 35 is considered a strong indication for amniocentesis; however, recent indications from this same collaborative study suggest that a majority of infants born with trisomy 21 are from women under age 35. Furthermore, the sperm may carry the flaw in as many as 24 percent of cases. This suggests that screening criteria for Down's syndrome may have to be revised.

Finally, it has been pointed out that, if all pregnant women at or over age 35 underwent amniocentesis, the laboratory facilities for karyotyping the fetuses would be severely overtaxed. If appropriate biochemical and staining procedures were also to be performed on all available amniotic fluid cell cultures, it is not known how many other rare inborn errors of metabolism might be uncovered and at how great an expense. Pilot studies should be attempted to determine the cost-effective level of testing.

Neonatal screening tests

Newborn screening tests are now seeing increasing popularity for mandatory use in the several states. Such tests are selected for sufficiently frequent conditions that are treatable and clearly defined. They must be inexpensive, yet reliable, with few to none false positives. It can be argued that parents should learn of untreatable conditions, such

Continued on page 98



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as Duchenne muscular dystrophy, as soon as possible, so that additional pregnancies will not be innocently undertaken in the years that may pass before the disease is clinically recognized. However, many physicians feel it is not in the child's interest to advise the parents of the handicap so far in advance of clinical manifestations.

Tests that are now mandatory in 13 states include a test on a blood spotted filter paper for phenylketonuria and hypothyroidism. Fewer states also include tests for galactosemia and maple syrup urine disease. In New York State, branched chain ketonuria, homocystinuria, adenosine deaminase deficiency, histidinemia and homozygous sickle cell disease are all required, in addition.

At the minimum, it is probably cost effective now to expand the neonatal blood spot testing for hypothyroidism and phenylketonuria to include maple syrup urine disease, homocystinuria and galactosemia as well. In the future, many more conditions may be recognizable from a single neonatal sample of blood or urine.

Reproductive options

Patients found to be heterozygous for an autosomal dominant characteristic, found to be carriers of X-linked recessive conditions (such as hemophilia or Duchenne muscular dystrophy), or known by previous experience to be carriers for a serious multifactorial hereditary condition (neural tube defect) have several options.

If the risk of recurrence in a subsequent pregnancy is low, they may be willing to risk other pregnancies and, depending upon the diagnostic possibilities available for that condition, run the risk without entertaining those diagnostic studies that could lead to abortion.

Others might elect to continue efforts at pregnancy, planning to terminate any fetus that proved to carry a defect. In either case, the decision should probably not be made too soon after delivery of the first defective fetus.

If the recognized familial condition carries a heavy burden in the eyes of the couple, sterilization may be requested. Adoption of a child may provide a satisfactory substitute, but this is becoming increasingly difficult to arrange. When the husband is the carrier of an autosomal recessive gene (Tay-Sachs disease), artificial insemination may be a suitable option.

It may be concluded that, although the value of prenatal screening in recognition of certain genetically defective fetuses is becoming widely accepted, the case for widespread carrier screening for common heterozygous abnormalities is far from established.

Genetic counseling facilities

Parents of a child discovered to have a genetic defect need to receive professional advice concerning the child's prognosis, with options for preventing a recurrence of the problem and for managing the disability, when that is possible.

More importantly, they may gain support from others who have faced the same problems.

In most towns of over 10,000 population there is an organization for parents of mentally retarded children known as The Mental Retardation Association of America. There are also national organizations for some of the more common genetic defects: Association for Sickle Cell Anemia, Hemophilia Foundation, Little People of America, Muscular Dystrophy Association, National Cystic Fibrosis Research Foundation, National Paraplegia Foundation, Parents of Down's Syndrome and Spina Bifida Association of America, are examples.

Affected parents can be referred to such organizations for group support of this type.

More important for the medical profession is the need to develop professional counseling centers with broad prenatal diagnostic capabilities.

In parallel with the explosion in genetic knowledge of recent years, there has been rapid growth in genetic counseling centers. In the US there were said to be 10 counseling centers in 1951, 25 in 1961, and 400 in 1974. In 1976 the National Genetic Disease Act was passed by Congressional action which mandated development within the Bureau of Community Health Services of the Health Services Administration, of a National Clearinghouse for Human Genetic Diseases. This agency maintains a Directory of Clinical Genetic Service Centers that includes about 200 major university-based genetic counseling teams and another 150 satellite operations, as of 1980.

The program is administered through regional contracts, usually let to the State Health Departments.

The National Clearinghouse has been continued through FY 1982 by a block grant that is smaller by 25 percent than the amount of funding available in 1981. Current budgetary stringencies may require some limitations in availability of genetic services, but it is hoped that these important screening tests and adequate genetic counseling will not be seriously curtailed. The excellent progress of recent years in this area should continue.

The March of Dimes, since the elimination of poliomyelitis as a public health problem, has directed its efforts toward the prevention of birth defects and improving the outcome of a pregnancy. In the past 10 years, the March of Dimes has funded the establishment of many diagnostic and counseling centers, many of which are now supported by funds appropriated under the National Genetic Diseases Act.

An international directory of resources for diagnosis and counseling in genetic disorders is also published by this organization. This directory contains information on individuals in the field and the types of services they provide. The March of Dimes also funds research to investigate causes and prevention of birth defects and new approaches to treatment. In company with efforts to improve prenatal, perinatal and neonatal care, the development of genetic services in underserved areas remains a high priority of the March of Dimes.

References are available from MSMS

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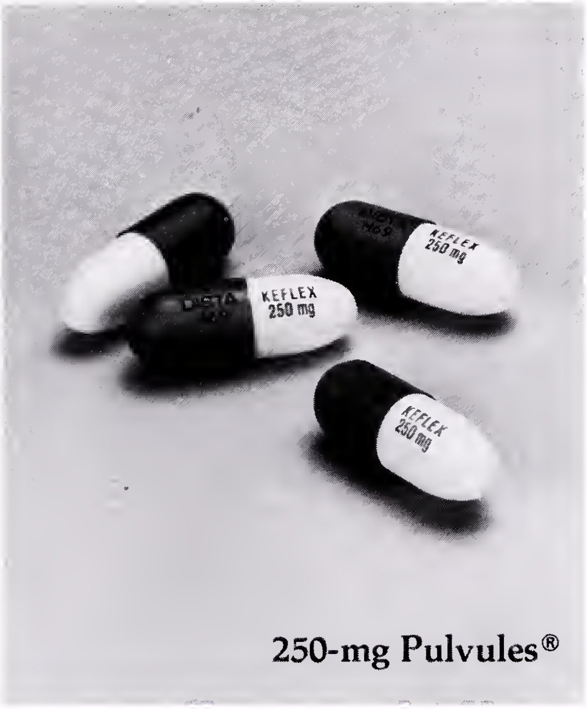

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MDPH goes after statistics of mild, as well as severe, vaccine reactions

By Byron S. Berlin, MD
Lansing

Informing parents of risks attendant to vaccination of their children is now almost as important as giving the vaccine.

However, physicians and health professionals often have inaccurate perception of the frequency of local and systemic complaints during the 72-hour period following vaccination with DTP because it is chiefly the more severe reactions that are brought to their attention. In contrast, mild reactions are minimized.

In June and July, 1981, the Bureau of Disease Control and Laboratory Services, in cooperation with five local health departments, used an active reporting system to solicit data concerning the frequency of adverse reactions following vaccination with DTP made and distributed by the Michigan Department of Public Health (MDPH) in public health immunization clinics.

Instead of relying on a passive reporting system which depends on the willingness of mothers of vaccine recipients or persons responsible for their care to notify appropriate health professionals, mothers were asked to answer a questionnaire regarding possible reactions during the three-day period following vaccination.

Specifically, the mother was asked if fever occurred and if so how high it rose; if pain occurred, and, if so, if it was mild, moderate, or severe; if there was a local lump or swelling and if so, its size; if there was limitation of locomotion or limb motion; and, finally, if other symptoms occurred.

Each mother was instructed to answer each question and return the questionnaire in a stamped, self-addressed envelope provided at the time of vaccination. Local health departments provided a list of recipients against which questionnaires could be compared to ascertain the completeness of return.

Three-hundred-eighteen (67.6 percent) of 476 questionnaires were mailed back to the Michigan Department of Public Health. Ninety-three of the children (29 percent) were from one to eight months old; 97 (30 percent) were nine months to two years old; and 128 (40) percent) were three years or older: ages which roughly corresponded to groups receiving first, second and third injections of DTP third and booster injections, and booster injections alone, respectively.

Unfortunately, a question concerning the number of previous DTP injections was incompletely answered by many mothers and, therefore, possible associations between injection number and the occurrence of a reaction could not be ascertained. Since there were no controls for this study, some complaints, particularly gastrointestinal and respiratory symptoms, might be unrelated to vaccination.

Results

Ninety percent of the vaccine recipients had post-vaccination complaints of sufficient intensity to alert the mother. Overall, 30 percent of the recipients showed febrile reactions of 99°F or higher and seven percent had fever greater than 102°F. However, the higher temperatures were seen only in recipients less than two years old **(Table 1)**.

Thirty-five percent of the recipients also complained of or were reported to have moderate to severe local pain at the injection site, while 39 percent were reported to show limitation of motion. Both complaints were reported in the same

Continued on page 102

TABLE 1
FREQUENCY OF ADVERSE REACTIONS TO DTP VACCINATION AT DIFFERENT AGE LEVELS

Post-Vaccination Complaint	Percent with Complaints at Each Age Level 1-8 mo.	9 mo.-2 yrs.	3 yrs.	"P"*
Fever >101°F	8.5	14	0	0.0003
Local Pain	21.5	38	44	0.003
Reduced Motion	23.7	40	54	0.001
Lump: >1" diameter	23.7	33	35	0.168
Number Vaccinated	93	97	128	318

*Based on X^2 calculation using actual number of occurrences.

Doctor Berlin is with the Michigan Department of Public Health Bureau of Disease Control and Laboratory Services.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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DTP REACTIONS/Continued

child with a highly significant frequency ($p < 0.001$) and, in addition, occurred with greatest frequency in children nine months or older **(Table 1).**

Lumps or swelling at the injection site measuring one inch or more were detected in 31 percent of the recipients. Although the association of local swelling and pain was statistically significant ($p < 0.001$), actually only 55 percent of the recipients who had local swelling also complained of pain at the injection site. Moreover, the likelihood of developing a lump at the injection site was not age-dependent **(Table 1).**

A variety of other complaints were reported in 23 percent of the recipients. Thirty-seven mothers described their children as irritable following vaccination. Five mothers reported that crying was a concern but only one reported that her child screamed after vaccination. Eight mothers reported that their children were sleepier than normal, and, in contrast, one child apparently did not sleep at all one night. Thirteen reported gastrointestinal disturbance: Seven vomited, three had loss of appetite and three had diarrheal stools. Three were reported to have a "cold" and one a headache.

Encephalitis, seizures, and neurologic complications were not reported in this study probably because of the small number of volunteers.

In summary, ninety percent of children vaccinated with DTP made by MDPH experienced a mild postvaccination reaction. Local complaints such as pain, local swelling and limitation of motion were the chief symptoms and occurred more frequently in recipients older than nine months than those younger than nine months. Thirty percent had a mild fever.

The frequency of mild complaints reported in this study compared favorably with findings of larger studies reported with use of commercially prepared DTP.

The author wishes to thank the local health departments of the cities of Detroit and Dearborn, and Wayne County, Ingham County and Washtenaw County.

References are available from the author.

Patients needed for asthma study

Recent studies have indicated that following the cautious administration of aspirin to patients who experience asthma from this drug, there is a refractory period during which they remain tolerant. The mechanism of this "desensitization" remains unknown (probably is not immunological), but some of these patients seem to have improvement in their asthma and nasal symptoms if they take aspirin daily following "desensitization."

Patients are needed who have asthma after taking aspirin; many of these individuals also have nasal polyps ("Triad asthma"). The protocol involves an eight-day admission to the Clinical Research Center following some preliminary studies. Costs are provided by a research grant.

Physicians should contact Kenneth P. Mathews, MD, Allergy Clinic, Box 27, University Hospital, Ann Arbor, 48109, (313) 763-3141.

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Michigan Board of Medicine disciplinary actions

Aug. 3 to Dec. 8

- **Albert Harold Keefer, MD**

209 Homer Street
Concord, 49237

Date, action taken

August 3, 1981
Limited License and Probation from 8-3-81 to 8-3-83

Violation

An Amended Final Order dated 4-2-80 put license on Suspension.

- **Ali Guner, MD**

108 S. First Avenue
Alpena, 49707

Date, action taken

September 2, 1981
Summarily Suspended effective 9-4-81

Violation

A departure from, or failure to conform to, minimal standards of acceptable and prevailing medical practice. Conduct or practice which impairs, or may impair, licensee's ability to safely and skillfully practice.

- **Stanley M. Lynk, MD**

4589 Lippincott Road
Lapeer, 48446

Date, action taken

September 2, 1981
Summarily Suspended effective 9-3-81

Violation

Incompetence. Selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes. Failure to use reasonable care and discrimination in the administration of drugs, and failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease; selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes; a departure from, or the failure to conform to, minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established.

- **George M. Shargel, MD**

28200 John R
Madison Heights, 48071

Date, action taken

September 2, 1981
Summarily Suspended effective 9-4-81

Violation

Incompetence. Selling or prescribing of drugs for other than a lawful purpose. Conduct which impairs or may impair his ability to safely practice.

- **Jerome James Wisneski, MD**

2338 Lake Michigan Drive, NW
Grand Rapids, 49504

Date, action taken

August 15, 1981
License Reinstated effective 8-15-81 (Reclassified from a Limited License to an Unlimited License)

Violation

Application for Reinstatement of Controlled Substance License.

- **John Joseph Manion, MD**

3920 Madison Avenue — Apt. #72
Wyoming, 48905

Date, Action taken

September 30, 1981
Suspended from 11-30-81 to 11-30-82
Probation from 11-30-82 to 12-2-85

Violation

Petitioned Board for reinstatement of his license.

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VIEWS

Cancer control terms need qualifiers; overall administrative organization, too

By John R. F. Ingall, MD
Detroit

It is the premise of some that only those who have known discipline can appreciate freedom. This applies to words as well as to behavior. The term "cancer control" implies a capability and complete authority over the disease; a goal to which we aspire, and in some small degree have achieved.

There is, however, an arrogant pretentiousness about the term "control" which may equate with our aspirations or conceit, but not with the state of the art.

Vogue term

"Cancer control," as a label, typifies the use of a vogue term subject to various interpretations. It is a bizarre experience to attend meetings, held by the elite of the cancer institutes, and hear an interminable dispute on the meaning of "cancer control."

It appears that the interpretation of congressional intent by the undisciplined use of words is a major hindrance to progress. The term "comprehensive" as a qualifier, implying as it does all things to all people at all times, is a prize example. Since control is not an absolute capability we must therefore qualify it.

Doctor Ingall is associate director for cancer control, Comprehensive Cancer Center of Metropolitan Detroit. He is a fellow of the American and Royal Colleges of Surgery.

Cancer control demands the application of the best methods, scientifically, clinically, academically, and organizationally available for the alleviation of pain and suffering due to cancer, and *in the light of present knowledge*, the implementation of measures feasible for its prevention. Many see cancer control as education. This assumes that the education registers, and improved methods are applied as a result thereof.

Efforts in cancer control, however, require organizational expertise in the community to ensure delivery of clinically advantageous discoveries to the entire community. Organization requires administrative "know-how" and a sensitivity to the personal and institutional components involved in the process. It is not achieved by fiat but by good administrative support of the professionals that will make it work.

The latter is not given sufficient dimension or support. Erosion of clinical time by administrative obligations is a malignant process in itself. Unfortunately, a physician with seniority in his chosen profession must show competence in an area for which he has not been trained.

The organizational process facilitating cancer control, as we understand it, requires greater emphasis.

Public pressure

Good ideas exist and await adequate implementation. They are administratively difficult and need time to implement. Institutions tend to respond to need, not as academically and clearly seen, but to public pressure which may be more emotional than scientific. Organizational support should be available to enable ventures of the highest possible calibre. Our efforts can then be aggressive rather than reactive. Investment of effort should be in areas where objectives outlined are most attainable and economically feasible.

The achievement of standards and fulfillment of expectations with short-term federal support for projects that are not supportable beyond the funding period inevitably rebound to the embarrassment of the initiator. A project once developed and successful deserves continuance in an operational rather than developmental framework. This demands that academic and humanita-

Continued on page 106

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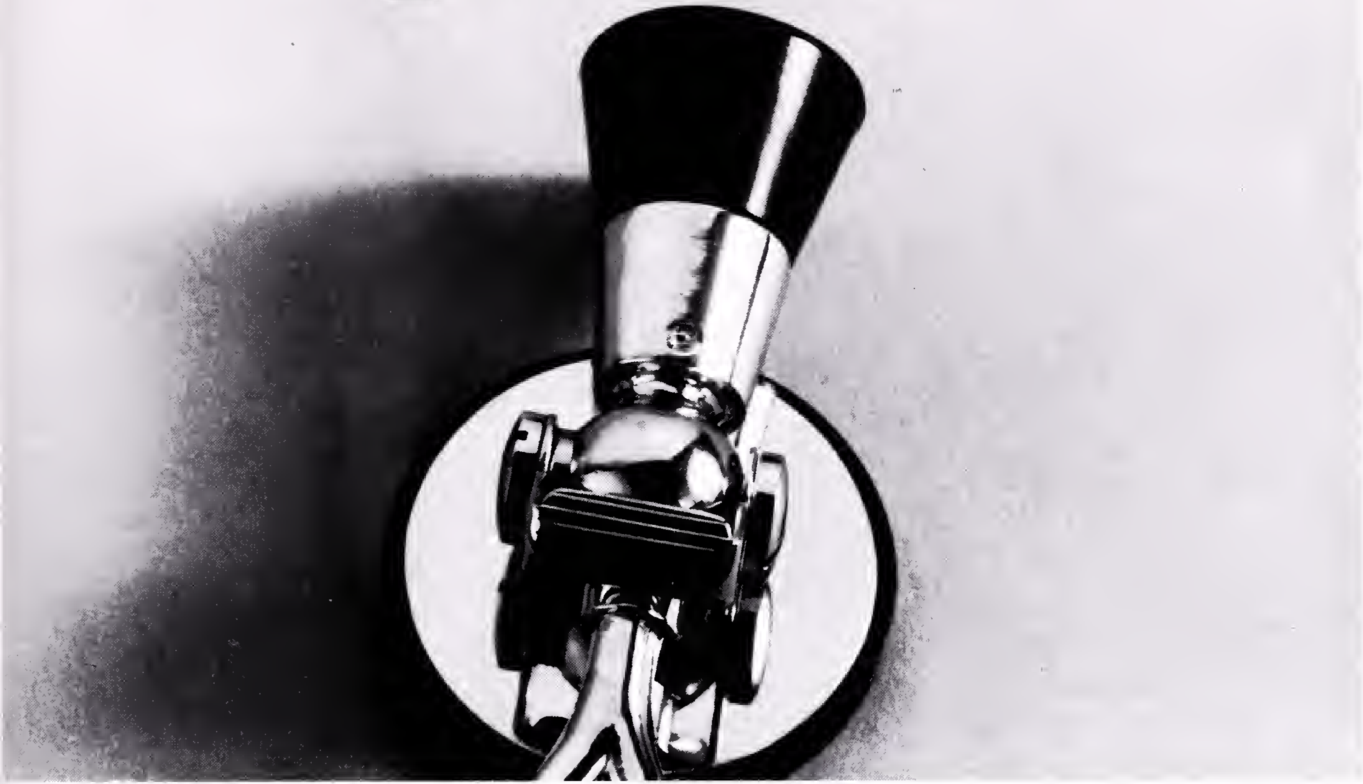

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rian ideals should equate with economic reality.

Any project, when initiated, should contain an evaluation plan and a mechanism for self support when the "venture capital" runs dry. A plan for cancer control has to be designed to survive the initial investment, and the vagaries of vogue and economic constraint at the federal level.

A system built of manageable components is preferable to an overall design with weaknesses.

To achieve this in an arena where institutional and personal promotion are necessary to survival is difficult. Success in cooperative ventures subsumes the identities of the participants. This doesn't help identity and promotion.

The change agent role can be achieved without question, but it has to be paid for. The Regional Medical Programs recruited participation from the private sector but fell prey to the disproportionate distribution of accolade for achievement to the participants rather than the convenor. It did not pay to be self-effacing when promotion was the name of the game.

Two steps

1. In the current pluralistic health care system, there is need for a publicly-funded, quasi-public "missing management element" to coordinate leadership and support roles amongst the fragmented federal, state, and private programs and among frequently competitive local interests.

2. For such a community organization to work optimally, it must *NOT* be co-opted or subordinated by a particular interest or interests. With the Regional Medical Programs, for example, early domination by medical schools sometimes led to a bolstering of tertiary medical center capability with really no intention, beyond lip service, to achieve outreach and community developmental activities. During the latter years of the Regional Medical Programs, the local organizations had generally evolved into a relatively well-balanced consortia of interests. They acted as a quasi-public agency capable of rapid and effective program production in various high-priority areas for which federal dollars and support became available. These programs became a unique and effective radical decentralization of authority for project grant awards, a role that the control and outreach components of the Comprehensive Cancer Centers might serve. Our current cancer control program efforts are complicated by a growing public expectation from technical capability to save lives or reduce suffering.

These disproportionate expectations are generated in the public mind by our "breakthroughs," technology, and terms such as control, comprehensive, and cure.

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New physicians have private practice option for underserved health care areas

By Alice Pletz
East Lansing

(Artwork courtesy of The Robert Wood Johnson Foundation.)

A new physician recruitment procedure is available to Michigan physicians, clinics, hospitals and communities looking for one or more physicians and located in one of the 48 Michigan counties where all or part of the county has been declared a Health Manpower Shortage area.

Opportunities to go into private practice in underserved HMSA areas are available now to physicians who have accepted financial assistance from the National Health Service Corps Scholarship Program. There are 163 medical students now in the four Michigan medical schools and 53 doctors in state residency training programs who are accepting NHSC aid.

Physicians and others trying to recruit physicians may obtain more information about this new possibility by writing Herbert A. Auer, executive vice president, Michigan Health Council.

Following are some general information and also answers to commonly asked questions about this private practice option for young physicians.

Ms. Pletz is a free-lance writer.

Under the National Health Service Corps (NHSC) Scholarship Program, a physician has a new method to fulfill his or her service obligation. For each year a medical student accepts financial assistance from NHSC, s/he is required to serve in an area designated as a Health Manpower Shortage Area. A minimum of two years is required.

The most recent method that has opened is the Private Practice Option (PPO). Under this option, the Secretary of Health and Human Services (DHHS) has been given the authority to release any individual who has incurred a service obligation under the NHSC scholarship program from all, or part, of their service obligation if the individual agrees to engage in full-time private clinical practice in a manpower shortage area (HMSA).

Those doctors wishing to recruit health practitioners through the NHSC for summer/fall 1982 must sign them on by March 1982.

Q. Who is eligible to go into the PPO?

A. Any health professions student who has incurred a service obligation by entering into an agreement under the Public Health Service NHSC Scholarship Program, and completed the academic training for which the scholarship was awarded is eligible to apply for a release to enter into a full-time private clinical practice.

Q. How many Michigan physicians will be available in summer/fall 1982?

A. There will be 46 physicians, now in residencies or internships.

Q. In what areas could a National Health Service Corps scholarship recipient elect the Private Practice Option (PPO)?

PRIVATE PRACTICE/Continued

A. PPO can be contracted only in the most acutely underserved areas, classified as Primary Care Health Manpower Shortage Areas.

Q. What is a Health Manpower Shortage Area (HMSA) and how is it determined?

A. A HMSA is an area determined by the federal government to have insufficient doctors to serve the area's population (based on a ratio of population to practitioners.) Each HMSA is assessed a priority level from 01-04, based on the degree of need. Under new legislation, the NHSC practitioner may complete the PPO in all four levels, with 01 areas still having the highest priority. (See map for HMSAs designated in Michigan.)

Q. Approximately how many service areas are there in Michigan?

A. There are approximately 40 in the Lower Peninsula and 10 in the Upper Peninsula.

Q. How can an NHSC scholarship recipient satisfy his/her service obligation as an independent practitioner in a shortage area under the PPO, rather than as a federal employee?

A. They are now able to work as a traditional private practitioner, a member of a group practice, or as a salaried employee of a health care facility in an underserved area.

Q. Under the PPO, who pays the individual's salary?

A. Since the individual no longer would be tied financially to the federal government, the individual would be paid by a hospital, medical care clinic, physician, or the agency for which s/he worked, or by the revenues s/he generates from the practice.

Q. What process must an individual go through for entry into the PPO?

A. There are two steps to entering the PPO:

1. An application must be made to Region V, Department of Health and Human Services, Chicago, where it is reviewed and approved;

2. A written contract must be made with the Secretary of Health and Human Services.

Q. Are there any minimum requirements which must be met?

Yes, there are nine which will be covered briefly here:

1. Service in or near a designated HMSA where 80 percent of the clients served are residents of the HMSA; and if a practice site is not located in a HMSA, but near it, the physician will have to conduct a three-day patient origin study to determine what percent of clients served come from HMSA;

2. A salary no less than the scholarship recipient would receive as a member of the NHSC.

3. Provision by physician of full-time private clinical practice of his/her profession (a minimum of 40 hours per week for 45 weeks per year);

4. Full-time private clinical practice by physician of his/her profession for a period of time equal to all or part of the service obligation incurred by the individual under the scholarship program;

5. Charges at prevailing rates customary to the area and services provided at no charge, or reduced charge, to persons of limited income. All Medicaid and Medicare patients must be served;

6. Non-discrimination in the provision of services.

7. Completion of a non-technical annual report which would include basic data on patient encounters;

8. Agreement to a periodic inspection of the private practice to be conducted by the Secretary, or a representative of the office;

9. Practitioner licensed by applicable State agencies.

If more information is required, please contact:

Pam Giering
Michigan Dept. of Public Health
Division of Health Care Systems
3500 N. Logan, P.O. Box 30035
Lansing, 48909
(517) 373-1746

or

Nancy Hazelton or Sally Walters
Placement Consultant
National Health Service Corps
Dept. of Health & Human Services
Region V
300 S. Wacker Dr.
Chicago, 60606
(312) 353-5007

MEDICO-LEGAL/Continued

cards which do state that the subscriber consents to the examination by the Blues of all medical, hospital and other records. The Blues therefore argue that because the subscriber contracts, certificates and I.D. cards allow Blues the right of review or audit; and because those instruments do not limit this right, the Blues have the authority to audit par and nonpar physicians' records on current accounts and on old accounts.

We are not inclined to give much credence to the print on the I.D. cards. What patient ever really examines that card? It is also argued that the patient has no choice: if he does business with the Blues or, more likely, if his employer does it for him, he is powerless in the negotiation of the "contract" and that these matters, if adverse to his interests, are contracts of adhesion.

Are the names of the patients whose records are under audit always protected? And even if they are, does there come a time when the Blues need to know those names in order to make various technical comparisons with respect to utilization of services? Assuming again, while we are arguing, that the names are kept private, does this give the Blues the right to move in and audit records of a physician who is not in contractual privity with the Blues or who may be at most a per-case participant?

Better choice

Somehow the equities must be balanced. Some need for audit supervision is probably indicated. The rights and the anonymity of the patient must certainly be protected. Finally, the individual physician and his bookkeeper must not be harassed and there should be a definite time limit on any limited right of audit.

If this thorny problem is not to drag on and on, there are only two methods of resolution: (1) litigation; or (2) some ongoing dialogue between organized medicine and third party payers to minimize the friction and to hold audit/review to a reasonable minimum.

The better choice is obvious.

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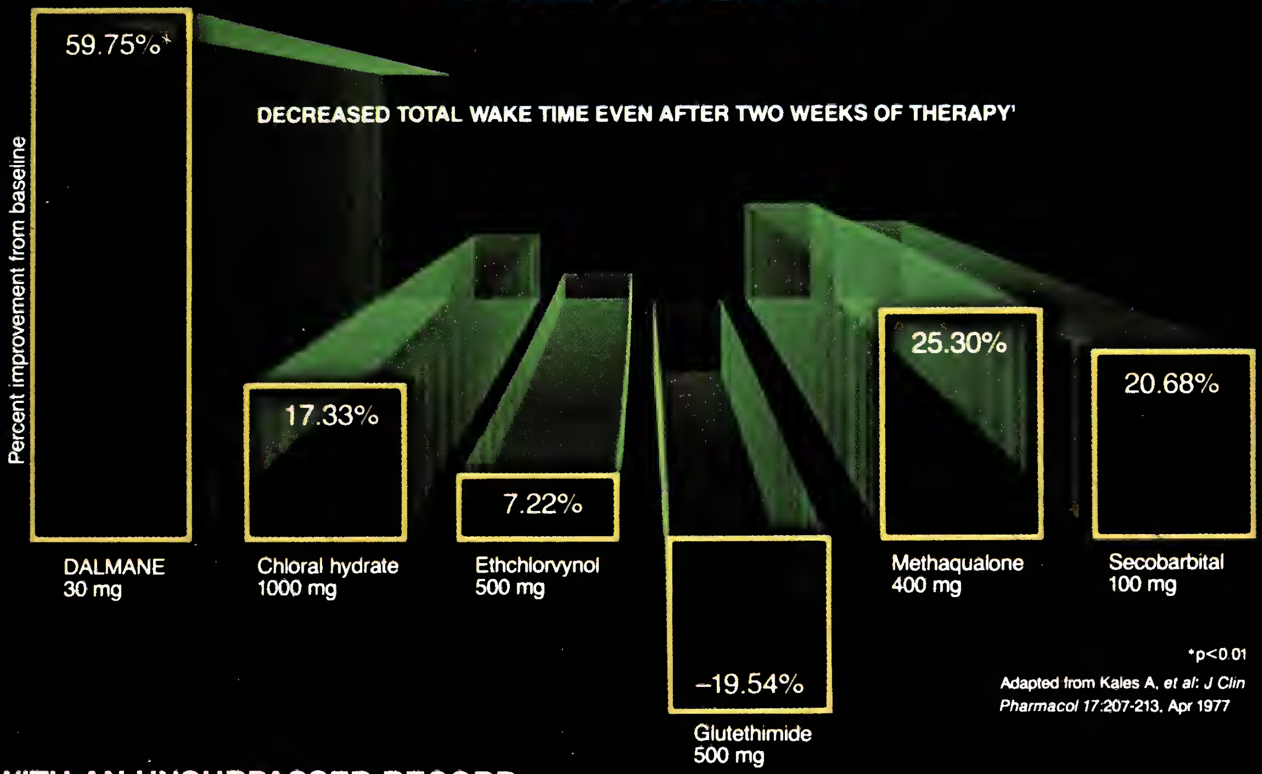

*$p<0.01$

Adapted from Kales A, *et al*: *J Clin Pharmacol* 17:207-213, Apr 1977

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Should insomnia recur, the patient may require guidance in setting up a regular sleep program to help provide the optimum environment for the onset of natural sleep. If hypnotic therapy is required, it should be given for the shortest time at the lowest effective dose to achieve the desired goal.

Consider other medications the patient may be taking (including alcoholic beverages) and be aware of possible drug interactions. Please note that patients should be treated for underlying physical or psychological factors before therapy with a sleep medication is undertaken.

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–which can require careful monitoring in cardiovascular patients[10]
–which have strong anticholinergic effects[10]

Antihistamines

–which are *not* reliable sleep-inducing agents[11]
–which may produce stimulation instead[11]
–which have anticholinergic effects[11]

Major tranquilizers

–whose side effects may be troublesome for nonpsychotic patients[12]
–where tolerance for sedation appears rapidly[12]

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.[4]

References: 1. Kales A, *et al*: *J Clin Pharmacol 17*:207-213, Apr 1977 **2.** Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **3.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977 **4.** Kales A, *et al*. *Clin Pharmacol Ther 18* 356-363, Sep 1975 **5.** Moore JD, Weissman L: *J Clin Pharmacol 16*:241-244, May-Jun 1976 **6.** Spiegel HE: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **7.** Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, pp. 641-646 **8.** Warfarin Study: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **9.** Baldessarini RJ: Drugs and the treatment of psychiatric disorders, chap. 19, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp. 391-447 **10.** Cole JO, Davis JM: Antidepressant drugs, chap 31 2, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1941-1956 **11.** Douglas WW: Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap. 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp. 609-646 **12.** Davis JM, Cole JO. Antipsychotic drugs, chap 31 1, in *Comprehensive Textbook of Psychiatry/II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.
Adults: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Thank you for Michigan Foundation student scholarships

I am writing on behalf of our many medical school students who have received assistance from the scholarship and/or loan programs which your contributions from the Michigan Foundation of Medicine and Health Education, Inc. have made possible. We thank you for the generous support you have given the medical school, and your $3,698 check this year.

I am taking this opportunity to report to you on our financial outlook for the next period of time. Last year 876 students, or 87 percent of our student body received financial assistance; this year the need is even greater.

In anticipation of lean years to come, we chose to use your contributions sparingly and to allow them to generate additional dollars in reserve as long as federal and state monies were available for our needy students.

However, due to the severe retrenchments in our funding this year we have spent more of our accumulated reserves than we had anticipated would be necessary in any one year. In order to maintain the high level of academic achievement and to make it possible for students who come from low and middle income families to attend our school, additional funds must be available to replace those lost through state and federal cutbacks.

Many of our private scholarship and loan programs were initially set up so that they serviced particular groups or classes of students. Many loan programs were authorized only for short-term loans. Our system as well as our needs have changed with the changing conditions. It is now imperative that we have more funds available for long-term loans to students as opposed to short-term loans. It is also necessary that the financial aid officer have the flexibility to assign the contributed funds in a discretionary manner, as the need arises.

President Reagan's economic package, as legislated by the 97th Congress, has had a profound effect on medical education. Among those programs seriously affected is the Guaranteed Student Loan Program. Approximately 25 percent of our currently eligible students may be eliminated from eligibility for these loans.

The Health Education Assistance Loan Program is being projected by the administration and the Office of Management and Budget as the answer to the needs of our medical students. Currently this loan is being made at 19½ percent interest, accrued and compounded beginning the day of the loan. There is a 10 to 25 year repayment period after graduation. Repayment is eight and one-half times the amount of the initial loan (a $10,000 loan over a 10 year period @ 18½ percent interest would cost $85,800). We question the effect of such loan obligations on the medical profession of the future.

In addition, within the past two to three years four major loan programs have been terminated, limiting loan sources dramatically. They are as follows:

1. American Medical Association Education and Research Foundation
2. Robert Wood Johnson Foundation
3. De Waters (Genessee County)
4. Blue Cross/Blue Shield

The above gives you a birds' eye view of the problems facing this office and our needy medical students.

Again, thank you for your past, present and future support. This support is vital to our school in many ways. With your continued cooperation and support and through our joint efforts, I am confident that we shall overcome our difficulties.

Matilda Bobbie Graff
Financial Aid Officer
Office of the Dean
School of Medicine
Wayne State University

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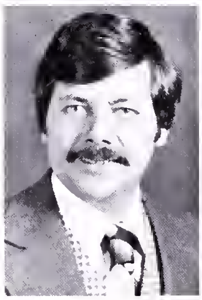
NEWS

By Sheri W. Greenhoe
East Lansing

Engelke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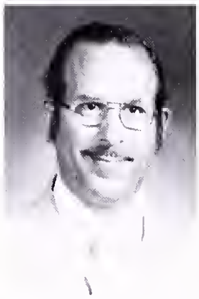
MacKenzie

Mehregan

One of only five scientists worldwide to receive the Anna-Monika Foundation Prize is **Bernard J. Carroll, MD,** professor and acting chairman of psychiatry at the U-M Medical School. Doctor Carroll was awarded the West German honor for his research findings on the biological causes of depression. . . . New president of the Michigan Society of General Surgeons for 1982-83 is **John C. Rienstra, MD,** Grand Rapids. . . . Grosse Pointe physician **Frank Nesi, MD,** vice chief of ophthalmology at Grace Hospital and director of the Eye Trauma Service at Detroit Receiving Hospital, is author of a text entitled "Practical Techniques in Ophthalmic Plastic Surgery." . . . **Robert Johannesen, MD,** Marquette, is new assistant director of the Marquette family practice residency program of the Upper Peninsula Medical Education Program. The program is designed to improve the number and distribution of physicians practicing in the UP. . . . Washtenaw County's first public health director, **Otto K. Engelke, MD,** also MSMS past president, was honored with a bronze plaque Dec. 22 by the Washtenaw County Board of Commissioners and the Washtenaw County Medical Society. The plaque is permanently mounted in the county courthouse lobby, and cites Doctor Engelke as "The Guardian of Public Health." . . . *From X-Ray Martyrs to Low Level Radiation* is the title of a new publication by **Roscoe Hildreth, MD,** Kalamazoo. Doctor Hildreth spent two and a half years researching and writing the publication in response to the American College of Nuclear Medicine's call for the medical profession to combat the spread of unsubstantiated fear about radiation. . . . **Robert O. Northway, MD,** who retired from medical practice in 1979, was honored recently by the reactivated Saginaw Surgical Society for his contributions to the profession. Doctor Northway was one of the founders of the society. . . . Menominee County physician **Fred Ayers, MD,** received statewide recognition from his colleagues at MSU's Family Practice Research Day held in Lansing in November. A paper authored by Doctor Ayers and medical student **Kenneth Granke** was awarded first place during the two-day seminar. It identified factors that could cause a hospitalized patient to slip and fall. . . . New officers of the Michigan Society of Therapeutic Radiologists are: **Joel White, MD,** Detroit, chairman of the board; **William E. Powers, MD,** Detroit, president, and **Harold Perry, MD,** Detroit, president-elect. . . . **John W. MacKenzie, Jr., MD,** Swartz Creek, was installed as president of the Michigan Chapter of the American Academy of Family Physicians during the chapter's recent annual meeting in Traverse City. . . . **Gilbert Bluhm, MD,** Detroit, has been named a member of the Michigan Hospital Association Committee on Cost Containment, which formulates Association policy and implements programs to carry out the National Voluntary Effort to prevent unnecessary health care expenditures while seeking to assure optimal value from necessary expenditures. . . . New president of the American Society of Dermatopathology for 1981-82 is **Amir H. Mehregan, MD,** Monroe. Doctor Mehregan was installed during a recent Society meeting held in San Francisco. . . . A new vocational/technical center in Detroit has been named after the late **Ethelene Jones Crockett, MD,** who was director of the Detroit Maternal/Infant Care Project. The facility is on the fringe of Detroit's Medical Center complex, and trains students in nine medical areas. . . . The Galens Medical Society, made up of U-M medical students, collected donations for the 54th time in December, to raise funds for medical care of infants, children and teens in the greater Detroit area. The group collects donations annually, and last year donated more than $84,000 to health care causes. . . . **Bennard J. Dowd, MD,** retired in December from his 47-year family practice in Kalamazoo. Except for time out for the war, Doctor Dowd practiced at his Kalamazoo "Doctor's Row" location for the entire duration of his career. . . . **Billy Ben Baumann, MD,** Pontiac, has been appointed to the AMA Committee on Allied Health Education and Accreditation, and **James J. Humes, MD,** Detroit, has been appointed to the AMA Residency Review Committee for Pathology. . . . **Alfred B. Swanson, MD,** was a guest lecturer at a three-day symposium on Hand and Orthopaedic Surgery, at the Shriners' Hospital in Mexico City, where he was made Honorary Member of its teaching staff. He also lectured to the Mexican Orthopaedic Society during his stay.

Ms. Greenhoe is editorial secretary to *Michigan Medicine*.

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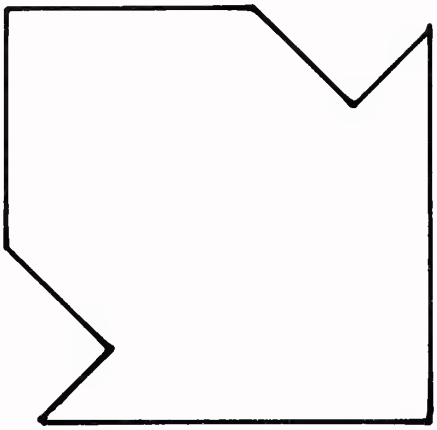

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

John R. Armstrong, MD PUL
2321 Indian Hills Dr.
Okemos 48864

John A. Axelson, MD IM/HEM
500 Lansing Ave.
Jackson 49201

Michael J. Baker, MD IM
2335 Pontiac Lake Rd.
Pontiac 48054

Dennis A. Boysen, MD GS
1020 Almira St.
Saginaw 48602

Cleofe J. Chavez, MD PD
1414 W. Fair Ave.
Marquette 49855

Steven J. Danek, MD PUD/IM
1414 W. Fair Ave.
Marquette 49855

Joseph L. DeCook, MD OBG
1021 Central
Holland 49423

Aziz A. Dhedhi, MD GS
VA Medical Ctr.
Iron Mountain 49801

Shiang-Hui Foo, MD IM/GE
128 E. Butler
Adrian 49221

Mumtaz George, MD IM
33730 Harlan
Farmington Hills 48018

Inad Haddad, MD IM
4204 W. Maple Ave.
Adrian 49221

Thomas D. Harris, MD D
1514 Fourth St.
Jackson 49203

John Hebert, III, MD OBG
5014 N. Saginaw St.
Flint 48505

H. Mark Hildebrandt, MD PD
940 Maiden Lane
Ann Arbor 48105

Alexander Iwanow, MD EM
401 E. Grand River
Brighton 48116

Michael K. Kobernick, MD FP
241 Maplewood
East Lansing 48823

Karl F. Kolbe, MD IM
36300 Van Dyke
Sterling Heights 48077

Willy Krauss, MD P
827 N. Michigan Ave.
Saginaw 48602

Anita Kumar, MD PD
36300 Van Dyke
Sterling Heights 48077

Alex Maximovich, MD OBG
15692 Buckingham
Birmingham 48009

Ramesh C. Misra, MD IM/CD
302 Kensington Ave.
Flint 48502

Krishna Mohan Jain, MD CDS
1717 Shaffer Rd. #233
Kalamazoo 49001

Joseph G. Rhode, MD FP
1200 Byron Rd.
Howell 48843

Thomas J. Schnur, MD PD
20436 Edmunton
St. Clair Shores 48080

Duen S. Shih, MD AN
74 Carlyle Ave.
Coldwater 49036

Stephen L. Smiley, MD IM/ON
1001 Medical Park Dr.
Grand Rapids 49506

Prabhas Tung, MD PS/GS
2710 W. Court St. #7
Flint 48503

Bradford L. Walters, MD EM
26559 Berg Rd.
Southfield 48034

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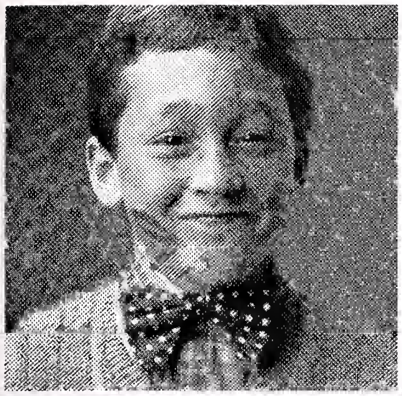

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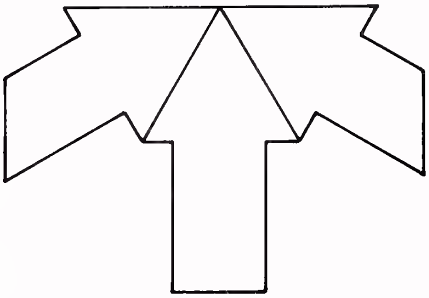
MEETINGS



MSMS, MSMS/A, AMA, and medical assistants

Feb. 23-25 — AMA Auxiliary Regional Cluster Meeting, for State Presidents, Presidents-elect and nominated Presidents-elect, contact: Caroline Rich, MSMS headquarters.

Feb. 24 — Michigan Society of General Surgeons Board Meeting, The Canopy, Brighton, contact: Caroline Rich, MSMS headquarters, (517) 337-1351.

March 5 — Impaired Health Care Professionals: A Challenge to the Professions, Westin Hotel, Detroit, contact: Marce Ireland or Sherry Fent, MSMS headquarters, 517/337-1351.

March 7 — Medical Assistants Board Meeting, MSMS Building, East Lansing, contact: Caroline Rich, MSMS headquarters.

March 10 — MSMS Council Meeting, MSMS headquarters, contact: Warren Tryloff, MSMS headquarters.

March 10 — MSMS/A Legislative Day, Civic Center, Lansing, contact: Caroline Rich, MSMS Headquarters.

April 7 — Workshop for Accredited CME Providers, Long's Convention Center, Lansing, contact: Marce Ireland, MSMS headquarters, 517/337-1351.

April 8 — MSMS Conference on Sports Medicine, Plymouth Hilton, contact: Mert Scholten, MSMS headquarters.

April 14-15 — 1982 Michigan Conference on Maternal and Perinatal Health, Grand Plaza Center, Grand Rapids, contact: Katie Brewbaker, MSMS headquarters.

April 30-May 1-2 — MSMS House of Delegates, Westin Hotel, Renaissance Center, Detroit, contact: Richard Campau, MSMS headquarters.

May 3-5 — 56th Annual Convention MSMS Auxiliary, Grand Plaza, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

May 6 — Women Physicians Conference: How to Use "the System," MSMS, Michigan Inn, Southfield, contact: Vada Davis, MSMS headquarters.

June 13-17 — Annual Meeting, American Medical Association, Chicago, contact: AMA, 535 N. Dearborn, Chicago 60610 (312/751-6000).

June — AMAA Convention, Drake Hotel, Chicago, contact: Caroline Rich, MSMS headquarters.

June 30 — MSMS/INTRAV Rhine River Adventure (14 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

July 11-14 — The Council Midsummer Session, Grand Traverse Hilton, contact: Warren F. Tryloff, MSMS headquarters, 517/337-1351.

July 18 — MSMS/INTRAV Alpine Adventure (15 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

Oct. 23 — Michigan Neurological Association Annual Meeting, Dearborn Inn, contact: Sheila Sheehow, MD, (313) 875-1913.

Other meetings

Feb. 4 — Accreditation Seminar for Hospital Laboratory Services, Detroit, contact: Julie Efaw at Joint Commission for the Accreditation of Hospitals Headquarters.

Feb. 12-24 — Medical Staff Issues and the Practicing Physician, Boyne Highlands, contact: Julie Efaw at Joint Commission for the Accreditation of Hospitals Headquarters.

March 5 — Impaired Health Care Professionals: A Challenge to the Professions, Westin Hotel, Detroit, sponsored by: American Society of Law & Medicine and other medical organizations, contact: Conference Registrar, American Society of Law & Medicine, 765 Commonwealth Ave., 16th Floor, Boston, MA 02215, (617) 262-4990.

March 10 — Ethical Perspectives on Medical Problems, a six-week course offered by Western Theological Seminary, Holland, covering organ transplants, alcohol and drug abuse, death and dying, contraceptives, artificial insemination, test tube babies, surrogate mothers, abortion. Contact: Bernadine Siebers-DeValois, MD, (616) 392-8555.

April 5 — Wayne County Medical Society 61st Annual Beaumont Lecture, Bon Secours Hospital, Grosse Pointe, contact: Wayne County Medical Society.

April 15-16 — Nursing Standards Seminar, Grand Rapids, contact: Julie Efaw, Joint Commission for the Accreditation of Hospitals Headquarters.

May 12-13 — Perinatology: Transitions, Trends and Tragedies, sponsored by the Southwestern Michigan Perinatal Association, Kalamazoo, contact: Valerie Lincoln, RN, Perinatal Coordinator, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo, 49006.

June 3-4 — Prevention of the Hereditary Large Bowel Cancer, sponsored by the Comprehensive Cancer Center of Metropolitan Detroit, Detroit, contact: John Ingall, MD, CCCMD, 110 East Warren, Detroit, 48201, (313) 833-0710.

June 25-27 — Michigan Association of Neurological Surgeons Annual Meeting, Birchwood Inn, Harbor Springs, contact: David Herz, MD, (616) 456-9507.

June 26-27 — Annual Meeting of the Michigan Orthopaedic Society, Hidden Valley, Gaylord, contact: Jerome Conrad, (616) 796-6721.

July 11-14 — Advances in Emergency Care, Ninth Michigan Emergency Medicine Assembly, Grand Traverse Hilton, contact: Catherine C. Sleicher (517) 332-6500. Deadline for submission of abstracts of original, unpublished scientific papers for presentation is May 1.

July 12 — Annual Membership Meeting, Michigan Chapter, American College of Emergency Physicians, Grand Traverse Hilton, contact: Catherine C. Sleicher, (517) 332-6500.

September 24-26 — Michigan Chapter American Academy of Pediatrics Annual Scientific Meeting, Grand Traverse Hilton, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018, (313) 553-3646.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Saturdays, 8:30 am to 11:30 am, Sept.-June. Orthopedic Conference. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Continuing Medical Education. **Contact:** Dr. E. Guise (313) 876-2188. **Approved for:** 3 hours of Category I Credit.

Date: Wednesdays, 7:00 am to 10:00 am, Jan.-Dec. Emergency Medicine Conference Series. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Continuing Medical Education. **Contact:** Dr. James Nowakowski (313) 876-1552. **Approved for:** 3 hours of Category I Credit.

Date: February 3, February 18, and March 10, Everyday Health Decisions: Whose Choice and How? Location: 3:30-5:30 session — Borgess Hospital Auditorium, then 7:30-9:30 session — Downtown Kalamazoo Location each day. **Co-Sponsors:** Kalamazoo Area Council for the Humanities and Southwestern Michigan Area Health Education Center. **Cost:** $15.00 All three sessions, $5.00 one session. **Contact:** Mary Godfrey, Kalamazoo Areá Council for the Humanities, Kalamazoo College, Kalamazoo 49007, (616) 383-8430. **Approved for:** 2 Category I hours per session, 6 Category I hours total for all three sessions.

Date: March 1-2, Sixth Annual Winter Pediatric Seminar. Location: Caribou Lodge, Powderhorn Ski Area, Bessemer. **Sponsor:** Marshfield Clinic and Marshfield Medical Foundation. **Cost:** $60. **Contact:** Marshfield Clinic Office of Medical Education, 1000 N. Oak Avenue, Marshfield, Wisconsin 54449 (715) 387-5207. **Approved for:** 8 hours of Category I Credit.

Date: March 10, Special Problems in Hypertension. Location: Kalamazoo Hilton Inn. **Cosponsor:** Bronson Nephrology and Southwestern Michigan Area Health Education Center. **Cost:** $65. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo, 49007. (616) 388-7877. **Approved for:** 7 hours of Category I Credit.

Date: March 10-12, 1982, Current Topics in Clinical Chemistry and Immunology. Location: Towsley Center for Continuing Medical Education, U-M, Ann Arbor. **Sponsor:** Office of Postgraduate Medicine and Health Professions Education. **For:** Physicians and technologists working in the field of immunology/chemistry. **Cost:** $185 or $95 per day. **Contact:** Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109, 313-764-2287. **Approved for:** 16.5 hours of Category I Credit.

Date: March 14-17, Carmel, California Infectious Diseases Conference: Advances in Diagnosis and Treatment. Location: Carmel-by-the-Sea Holiday Inn, Carmel, California. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School. **Cost:** $300. **Contact:** Wendy L. Frisch, Office of CME, Towsley Center, U-M Medical Center, Ann Arbor 48109, (313) 764-2287. **Approved for:** 11.5 hours of Category I Credit.

Date: March 24, New Approaches in the Diagnosis and Management of Ischemic Heart Disease. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **Contact:** Wendy L. Frisch, Towsley Center, U-M Medical School, Ann Arbor 48109 (313) 764-2287. **Approved for:** 8.25 hours of Category I Credit.

Date: April 1-2, Third Annual Pulmonary Rehabilitation Symposium. Location: Kalamazoo Center Hilton Inn. **Co-Sponsors:** Borgess Medical Center Pulmonary Unit and Southwestern Michigan Area Health Education Center. **Cost:** $65, one day; $80, both days. **Contact:** Pam Ely, Staff Assistant, Borgess Medical Center, Pulmonary and Special Diagnostic Services, 1521 Gull Road, Kalamazoo, 49001. (616) 383-7229. **Approved for:** 10 hours of Category I Credit.

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CATEGORY I/Continued

Date: April 3, Cardiovascular Disease and Anesthesia. Location: Kalamazoo Center Hilton Inn. **Co-Sponsors:** Kalamazoo Anesthesiology, PC, and Southwestern Michigan Area Health Education Center. **Cost:** $60. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, Southwestern Michigan Area Health Education Center, Stryker Ctr., 4th Floor, 1521 Gull Road, Kalamazoo, 49007 (616) 388-7877. **Approved for:** 7 hours of Category I Credit.

Date: April 16-17, Spring Symposium in Radiation Oncology. Location: Towsley Center for Continuing Medical Education, U-M Medical School. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **Contact:** Wendy L. Frisch, Towsley Center for Continuing Education, Box 057, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 12.75 hours of Category I Credit.

Date: April 20-24, Spring Family Practice Review: Clinical Update. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Office of Continuing Medical Education, The University of Michigan Medical School. **Cost:** $395. **Contact:** Wendy L. Frisch, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 35.5 hours of Category I Credit.

Date: April 22-23, Eleventh Annual Critical Care Symposium. Location: Michigan Inn, Southfield. **Sponsor:** Wayne State University, Department of Surgery. **Contact:** Theresa Sokol, (313) 577-5009. **Approved for: 12 hours of Category I Credit.**

Date: April 23-25, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: April 25-29, Midwest Conference on Alcohol and Drug Abuse. Location: Valley Plaza, Midland. **Sponsor:** Bay Medical Education. **For:** All interested physicians. **Cost:** $225. **Contact:** James R. Tarrant, Director of Medical Education, Bay Medical Education, 615 Ninth St., Bay City 48706, (517) 892-1501. **Approved for:** 19 hours of Category I Credit.

Date: April 26-30, Advanced Muscle Energy Tutorial (Below Diaphragm). Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: May 7-8, Nuclear Radiology Workshop with Minisymposia in Cardiopulmonary Nuclear Medicine and Updates in General Nuclear Medicine. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Office of Continuing Medical Education, The University of Michigan Medical School. **Cost:** $195. **Contact:** Wendy L. Frisch, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109 (313) 764-2287. **Approved for:** 15 hours of Category I Credit.

Date: May 17-21, Advances in Internal Medicine. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Office of Continuing Medical Education, The University of Michigan Medical School. **Cost:** $425. **Contact:** Wendy L. Frisch, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109 (313) 764-2287. **Approved for:** 35 hours of Category I Credit.

Date: June 14-18, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine, and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn,A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 18-20, 33rd Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University Department of Surgery. **Contact:** Theresa Sokol, (313) 577-5009. **Approved for:** 12 hours of Category I Credit.

Date: July 22-28, Intermediate Course on Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: July 30-Aug. 1, Arrhythmias and Cardiac Ischemia: Diagnosis and Management. Location: Boyne Mountain Resort, Boyne City. **Sponsor:** International Medical Education Corporation. **For:** Physicians, nurses and technicians. **Cost:** Physicians — $245, Nurses and technicians — $130. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, 64 Inverness Drive East, Englewood, CO 80112 (303) 773-1144 or 800-525-8646. **Approved for:** 13 hours of Category I Credit.

Date: Aug. 23-27, Tutorial on Direct Action Thrusting. Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: October 15-16, Cardiac Rehabilitation. Location: Hyatt Regency Dearborn. **Sponsor:** International Medical Education Corporation. **Cost:** $245. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive East, Englewood, CO 80112 800-525-8651 or 303-740-8445, ext. 123. **Approved for:** 13 hours of Category I Credit.

Date: Oct. 25-29, Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of category I Credit.

Date: Nov. 1-5, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Nov. 8-10, Manual Medicine to the Extremities. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Dec. 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

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Keith S. Fineberg, J.D.
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BOOK REVIEW

The Law of Medical Practice in Michigan

By Louis E. Heideman, MD
Birmingham

J. Douglas Peters, JD, Keith S. Feinberg, JD, and Donald A. Kroll, MD, PhD, Ann Arbor, Michigan. Health Administration Press. 426 pp.

This is a well written book covering the content promised in the title, with additional chapters on the authors' perceptions of the history and organization of health care delivery and of medical ethics.

It is most useful as an introduction to medical-legal concerns and less so as a definitive reference or as a textbook. It has an excellent glossary, lists of references and index. It is readable.

The only criticism is that it appears to reflect the inevitable biases of the authors so that alternative interpretations of occurrences, of law and of structure in the organization and delivery of health care are generally not presented.

Adversarial approach

The approach in this book is from the adversarial procedure for problem-solving. An orientation to consumerism and to the point of view of the "plaintiff's bar" seems to be evident.

A note of conflict of interest and of disclaimer seems appropriate. This reviewer served on an advisory committee to the project of which this volume is the final report. I also serve as a member of the board of directors of the Michigan Physicians Mutual Liability Company. I am a physician and a past-president of the Wayne County Medical Society and of the Michigan State Medical Society. Each of these experiences introduces its own bias. By way of disclaimer, I am not versed in law and therefore feel inadequate to comment on the degree of completeness and impartiality of presentation of the legal aspects contained in Chapters IV, V, and VI, but I will proceed to do so nonetheless.

The first two chapters include a number of areas in which I disagree with the authors; but these are matters of perspective and of judgement. They do, however, seem to reflect a fixed point of view which makes them of less value as a definitive text or reference. Although disagreeing with the authors in these areas, I would point out that they also include criticism of our present judicial system in at least three statements:

p. 196 ". . . the witness not volunteer answers where no question has been asked."
The implication here is that it is appropriate to conceal relevant information.

p. 197 "There is a tendency of current court procedures to obfuscate and conceal."

p. 271 ". . . the prosecution and defense are less interested in truth than in advancing their case . . ."

The legal chapters seem to be comprehensive. An exception is the allocation of one sentence to the consideration of the physician's responsibility in the reporting of unexpected deaths. This is a matter of concern to the physician when it occurs and an area in which we are not too well informed, as we do not encounter this situation with any frequency.

Ethical problems

Chapter VII is devoted to consideration of ethical problems faced by physicians. Like most such discussions, it raises at least as many questions as it resolves.

At times moral or ethical considerations are determined through a legal approach, which I suppose is inevitable when lawyers consider these issues. The reality of course is that it is not unusual to have conflict between the moral code, the medical ethical code, and the law. It is indicated that the physician is bound to do what the patient wants, but there is no discussion of how the decision is to be made when the patient's want is unacceptable to the physician.

The ethics of dealing with the "terminal patient" can use a definition. Does the patient become "terminal" at the time of diagnosis of a condition which is not amenable to treatment, given our present state of knowledge, and which will result in the death of the patient? Or is it at the time that the condition has progressed to such a point that it is clearly evident the patient is dying? The first allows the physician to stage the transmittal of information so that the patient can handle it more effectively. The latter permits no such time.

Good introduction

In a number of discussions the authors indicate that it is ethically required to make decisions on study and treatment on the basis of financial and social considerations of the individual. I was brought up committed to doing what is best for the patient and find it very difficult ethically to determine what is best on the basis of either the patient's ability to pay or on societal demands.

These few episodes are included as examples of why I consider this book a good introduction to medical legal matters which must be used with discretion. The authors point out in their introduction that the law is a living, changing entity subject to alteration by new laws, by new court decisions, and by reinterpretation of prior decisions.

I wish to reiterate that the authors have performed a useful function in the writing of this volume.

Doctor Heideman is past president of MSMS and the Wayne County Medical Society. He is on the board of the Michigan Physicians Mutual Liability Company.

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What are the rights of payor, physician and patient when records are audited?

By A. Stewart Kerr
Detroit

Kerr

The practice of third party audit is accepted as a fact of life by some Michigan physicians. Others resent the practice as an invasion of the physician's rights and of the patient's protection of privilege. The need for at least some double-checking by a company which disburses millions of dollars is, from the viewpoint of the third party payor, reasonable and understandable. There is a group of physicians, however, who, as a matter of principle, deeply resent the audit practices. Doubtless, too, the audits are not welcomed by the relatively few physicians who misrepresent the services on the billing forms.

What are the rights of the parties — third party payer, physician and the patients whose records are to be subjected to audit?

No litigation

Oddly enough, there has been almost no Michigan litigation on the subject. This suggests that perhaps the preponderance of doctors accept the practice. But that is not an adequate answer to the dozens of doctors who bitterly resent this "invasion." There have been perhaps less than half a dozen circuit court suits filed on this topic. Only one of these appears to have had a written opinion (in favor of audit) and none of them has received appellate court treatment.

Mr. Kerr is MSMS legal counsel.

Doctors who decry the audit practice state that if there is no Michigan law on the subject, then the Blues (for example) do not have any right of audit, that there is no contractual relation between physician and third party payers that grants such right, etc. And if it is claimed that the right of audit arises through a contract between patient/subscriber and the insurer, the patient is completely unaware of it and/or it is a "contract of adhesion."

The Blues maintain that the audit rights arise through language found in subscriber contracts, certificates and I.D. cards.

The Comprehensive Health Care Certificate (0821-9(B)) states that each member authorizes physicians (and others) to furnish to BCBSM information relating to hosptial services. And, says the certificate, physicians are authorized thereunder to permit the Blues to examine those records. That latter authorization to physicians, of course, is meaningless, and the earlier language speaks for itself.

The Complementary Group Service Certificate (2017-2(a)) carries the same language, as does the Complementary Non-Group Benefit Certificate (2018-0(B)).

The Preferred Group Benefit Certificate MVF-1 (1879-6(A)) has a stronger statement:

> "A subscriber seeking payment from BS shall furnish or cause the physician to furnish a report to BS in such form as BS shall prescribe and by the filing of such report shall consent and direct that BS may have full access to the data disclosed by the records and files of the physician and of the hospital . . .".

MVF-2 Preferred Group Benefit Certificate (1880-4) (1978) is also explicit:

> "A physician cliaming payment from BS shall furnish a report to BS . . . which shall remain confidential (except for the purpose of determining rights and liabilities arising under this contract relative to diagnosis and services given the member) and it is agreed that request for such service is authorization to the physician to make such report . . .".

Exact language

Thereafter we find the exact language which is set forth in Certificate MVF-1.

The A77 Group Health Care Benefit Certificate (4800) (1977) states that:

> "Each member hereby authorizes physicians, hospitals . . . to furnish to BCBSM, upon its request, information relating to services. . . . Physicians, hospitals — are hereby authorized to permit BCBSM to examine their records with respect to the services and to submit to BCBSM reports of the services . . . All information related to treatment of the individual member will remain confidential except for the purpose of determining rights and liabilities arising under this contract."

Here again we see the explicit provision with respect to the "member" but the purported authorization of the second sentence is suspect.

Apparently the Blues also place some emphasis on the subscriber I.D.

Continued on page 108

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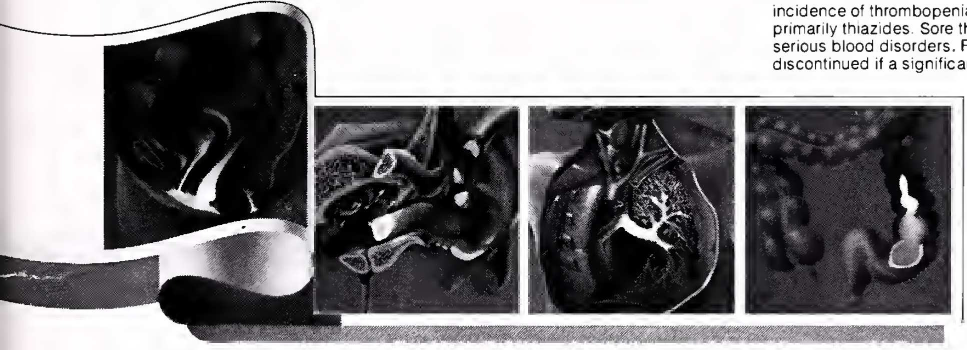

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Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE®

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Bactrim™ succeeds
in recurrent urinary tract infections*

from site to source

Bactrim™ DS
160 mg trimethoprim and 800 mg sulfamethoxazole
DOUBLE STRENGTH TABLETS

Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1]...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1]... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

maximizes results with B.I.D. convenience

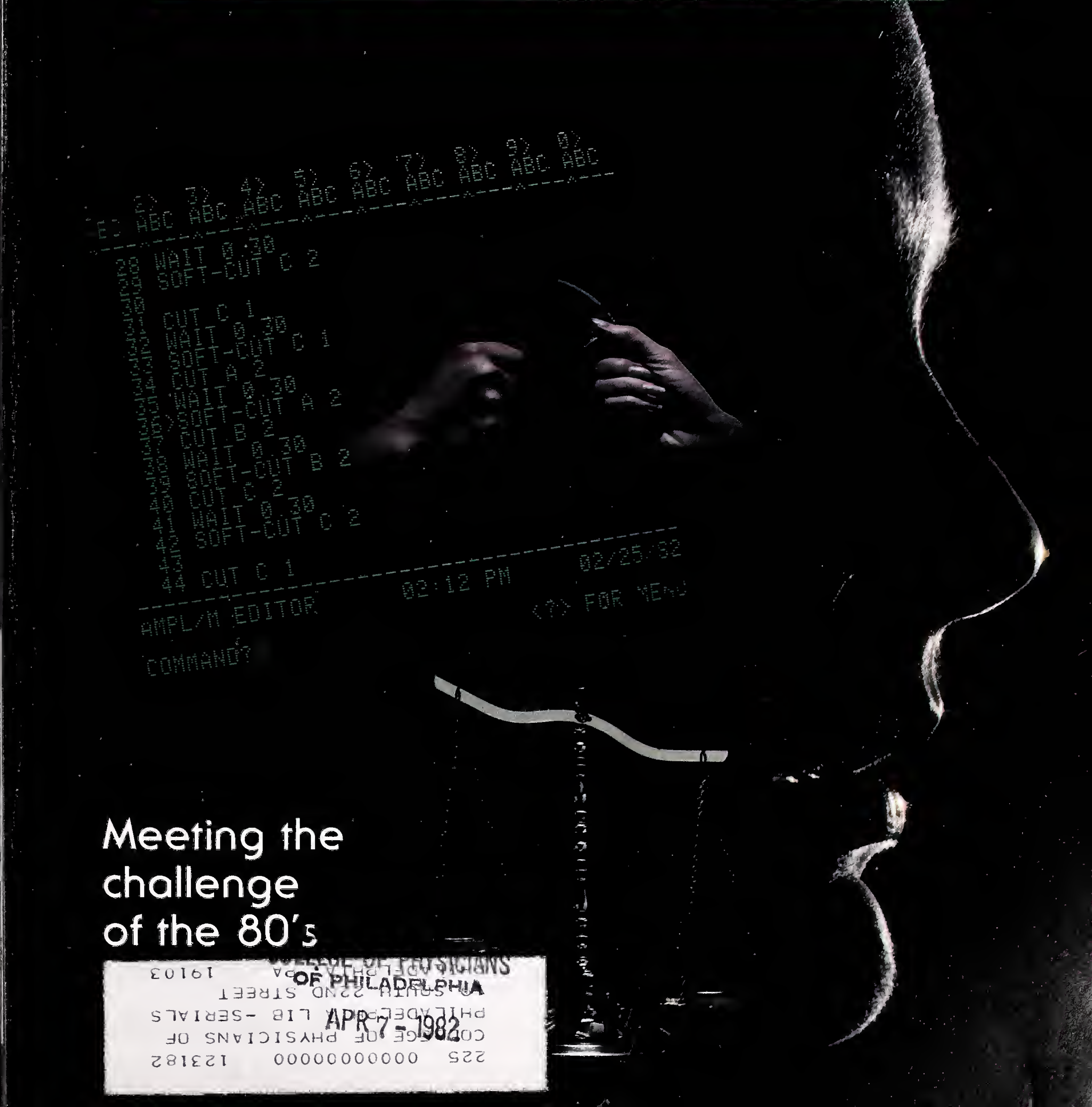
ROCHE®

*due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

MICHIGAN MEDICINE

March 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 81, No. 13



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Meeting the challenge of the 80's

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OF PHILADELPHIA
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"DESIGNER GENES"

1982 Michigan Conference on Maternal and Perinatal Health

April 14-15, 1982
Grand Center/Amway Grand Plaza
Grand Rapids

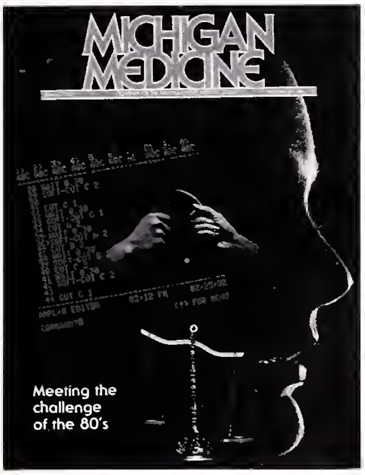
April 14

New Horizons in Perinatal Diagnoses
Michael M. Kaback, MD, UCLA
Prenatal Genetic Risk Assessment and Counseling
Elizabeth J. Thomson, RN, University of Iowa
Evaluation of Fetal Wastage
Sherman Elias, MD, Northwestern University
Recent Advances in Human Cytogenetics
James V. Higgins, PhD, MSU
Prenatal Diagnosis of Congenital Anomalies by Ultrasound
Peter Grannum, MD, Yale University
Recognition and Diagnosis of Sick Infants with Inborn Errors
Henry L. Nadler, MD, WSU
Diagnostic Evaluation of the Dysmorphic Child
Murray Feingold, MD, Tufts University

April 15

Population Screening and Perinatal Diagnosis for Metabolic Abnormalities
Michael M. Kaback, MD, UCLA
Serum Alpha Fetaprotein Screening
James E. Haddow, MD, Foundation for Blood Research, Scarborough, MA
Teratogens: Environmental Hazards for Fetal Development
James W. Hanson, MD, University of Iowa
Michigan Genetic Disease Program
William D. Young, PhD, MDPH, Lansing
Counseling Process in a Genetics Clinic
Diane Baker, MS, U-M
The Law and Genetics
Margery W. Shaw, MD, JD, Health Law Institute, Houston
Ethical Considerations in Genetic Screening
Joseph Fletcher, STD, D. Litt., University of Virginia

MARK YOUR CALENDARS NOW!



The major subjects of a new MSMS and *Michigan Medicine* self-help manual series to help physicians compete successfully in the 80s are symbolized on this month's cover. They are competition, practice management, communications and ethics. The special report which kicks off the magazine series begins on page 135, and is designed to be removed for handy reference. **(Roger Hill photo)**

MICHIGAN MEDICINE
March 1982, Volume 81, No. 13

Special report

135 It is going to take foresight, ingenuity, and knowledge for Michigan physicians to earn success in their professional and personal lives this decade. Your professional society begins a major effort with this issue to extend some help to its members. Beginning on page 135, Michigan Medicine publishes the first of a series of articles to arm Michigan physicians with information in four key areas: communications, competition, practice management and ethics. The entire special report in this issue is devoted to laying the groundwork for this new series, which will continue throughout 1982; Robert D. Burton, MD

Features

144 MSMS writes position statement on GMENAC Report; Kenneth J. Ray, MD

148 Most pro-competition health bills share these common elements; Deborah Zannoth

152 Board of Medicine disciplinary actions

154 Macomb County physicians combat drug abuse

175 Photo story: MSMS 'Calls in the team'

Departments

129 Letters

143 MSMS/A; Barbara Grennan

146 Issues and Angles: Is there a physician surplus in Michigan?

150 Views; Bailus Walker, PhD

156 Medical newsfronts

164 Medico-legal; A. Stewart Kerr

168 New members

170 News; Sheri W. Greenhoe

176 Category I courses

182 Meetings

186 Deaths

188 Classified advertising

189 Ad index

190 President's page; James D. Fryfogle, MD

Michigan State Medical Society

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Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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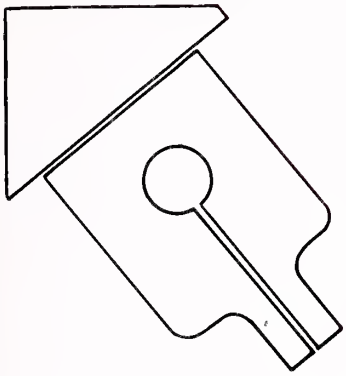
LETTERS



Deans meet

The following letter was received recently at MSMS Headquarters.

Just a brief note to say that I was delighted with the discussion the deans had with the MSMS Council yesterday (Jan. 27). It seemed to me to be a very highly desirable two-way exchange of opinions and information.

As we said at the meeting, we would certainly be pleased to do this in the future from time to time.

John A. Gronvall, MD, Dean
University of Michigan
Medical School

Where are the women?

RE: the photo of the MSMS Council in the December issue of *Michigan Medicine*: Where are the women?

Gail Barton, MD
Ann Arbor

Editor's note: MSMS Council Chairman Thomas R. Berglund, MD, agrees the time has come for women physicians to seek and fill leadership positions with MSMS. To that end, he points out, MSMS is sponsoring a conference May 6 at the Michigan Inn, Southfield, to help women physicians learn how to use the system better. All female members of MSMS are invited, and program details and registration forms are appearing in this month's issues of the *Medigram* newsletter. For details, please contact Vada L. Davis at MSMS headquarters, 517/337-3151.

Loved that cover!

Your January, 1982, issue featured a story on "Designer Genes", a conference to be held in April. The photograph on the cover of this issue was fascinating. Could you tell me if those designer jeans are available in the marketplace?

Sincerely,
Jeri Ryan, Librarian
American College of Surgeons
Chicago

I could not let it go by — the extraordinary cover of the January Journal helped me recall something which we discussed in medical school well over 40 years ago. In those days the expertise in genetics and eugenics had hardly reached the stage it now occupies and one of the major laboratory experimental animals — especially down in Champaign — was the Tse-tse fly. I well remember one day one of the profs remarking "If you have any interest in one's chromosomes all you have to do is pull down their 'genes' and evaluate." (And now we review chromosomes relative to their component genes!)

Anyway, tis a cute cover — nice clever jeans and not a distinctly unremarkable derriere. And I'm sure a nice assignment for Mert Scholten!

Harry D. Nesmith, MD
Disability Determination
Michigan Department of Education
Lansing

Love! the cover on the January issue, MICHIGAN MEDICINE! (Who posed?)

One correction I'd like to draw to your attention (which you couldn't have known, since it was just finalized last week): Our 1982 BULLETIN editor is William S. Floyd, MD (not Michael J. Miller, MD).

Mary Sue Meyer
Executive Director
Oakland County Medical Society
Birmingham

Just a note to applaud you and your staff for the sensational cover on the January issue of *Michigan Medicine*! Very clever idea!
Sincerely,

Michael DeVantier
Director of Medical Affairs
Michigan Division, Inc.
American Cancer Society
Lansing

Terrific, the designer genes cover! Much applause.

Ann Gray, Managing Editor
Virginia Medical
Journal of the Medical Society
of Virginia
Richmond, VA

If illness strikes

The following letter was sent recently to Managers of Michigan hotels and motels by the Convention/Visitors Bureau of Greater Lansing. The letter promoted the new MSMS emergency medical brochure for travelers, "If Illness Strikes."

The enclosed brochure is produced by the Michigan State Medical Society.

As you see, the brochure is designed as a service for travelers and/or meeting planners and delegates away from home, recommended to be carried in the glove compartment of an automobile or suitcase.

Many times in case of an emergency away from home a person's medical records could be invaluable to a physician treating an out-of-town person under such conditions.

You may want to offer a copy to your guests, either in the sleeping room, at the front desk or via the mail. Additional copies are currently available for pick-up in the Bureau office.

Suggest you consider placing the enclosed copy in your auto's glove compartment!

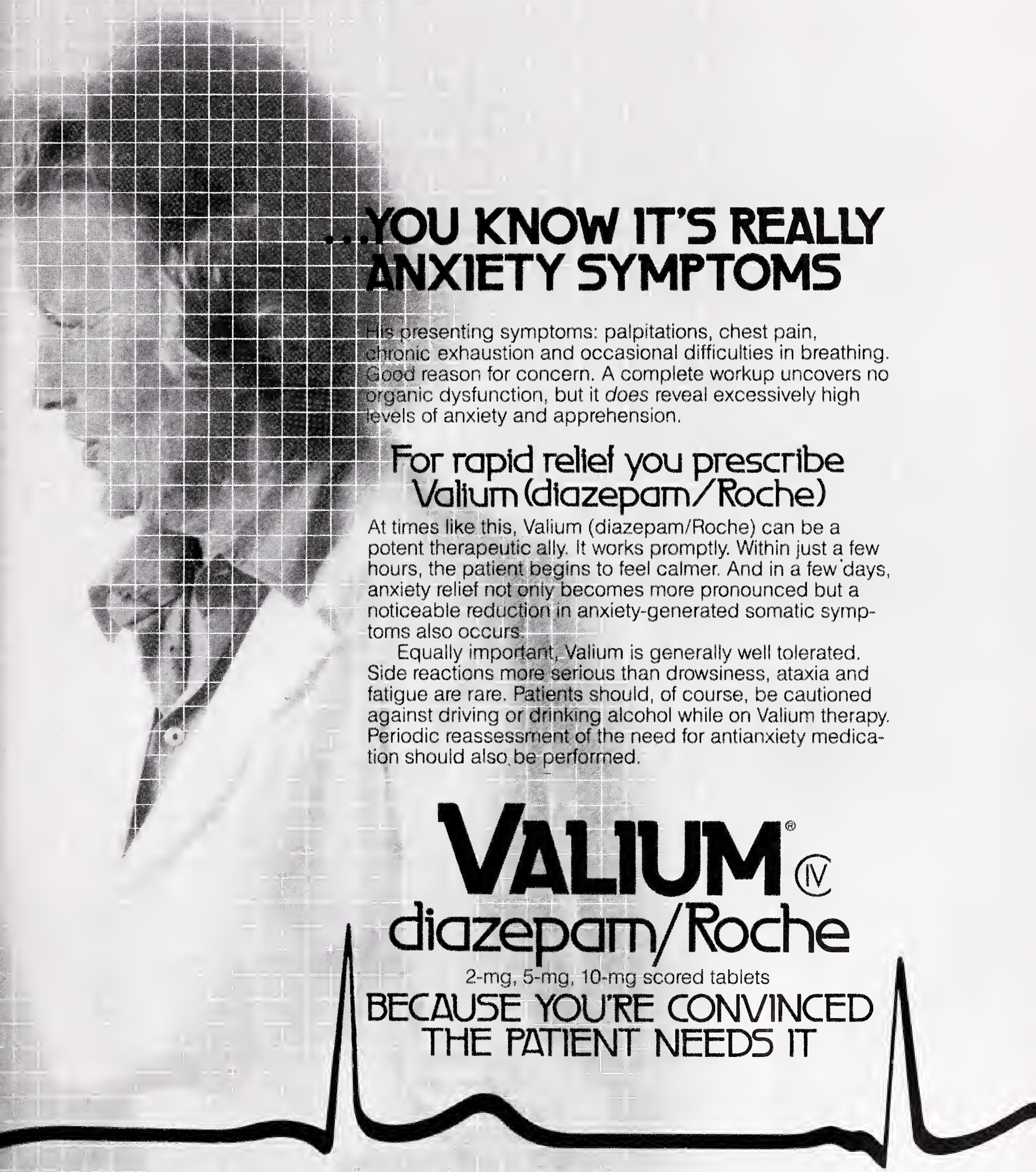
Regards,

Dick Carroll, Executive Director
Convention/Visitors Bureau
of Greater Lansing

Correction

The editor wishes to correct an error which occurred inadvertently in the article, "Michigan Medical Arbitration Program saves time," *Michigan Medicine*, January, 1982 . The article should have read, "The net result is that 43 percent (rather than 47 percent) . . . of the closed cases involved in the Michigan Arbitration Program have resulted in no award."

THE PATIENT THINKS
HE HAS HEART TROUBLE...



...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM® ⓘⓥ
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

ROCHE®

Please see summary of product information on the following page.

VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701
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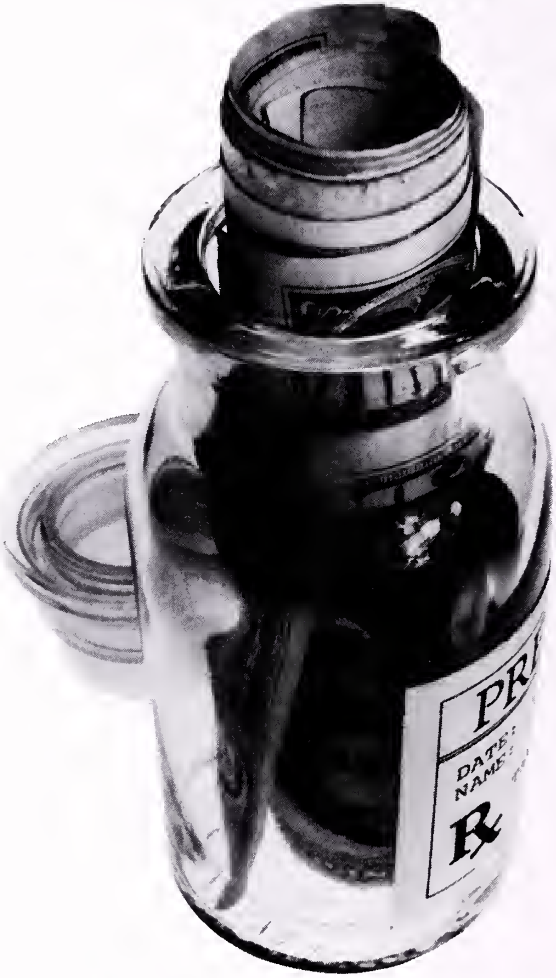
INSTANT CURES?



Sometimes there are.

The doctor may not have a bag full of instant cures, but we just might have some instant cures for the doctor. For instance, if your retirement program is an insured plan, we can show you how to cut costs *instantly* by changing to a trusteed plan. We're Watkins, Ross, Baines and Lamps, with some instant cures for problems confronting retirement programs. At WRB&L, we design all types of retirement plans for professional corporations. Once a plan is implemented, our services can provide you with the required actuarial reporting, while we monitor and periodically reevaluate the effectiveness of your program. We're one of the largest actuarial firms in the Midwest and work on an hourly basis.

Sometimes there are instant cures, at least when it comes to retirement planning for professional corporations. Call us. It's just what the doctors order.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® /5 Buccal mg. /10 Oral mg. /25 Oral mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen

another choice . . .

Introducing **ANDROID**® /F

Fluoxymesterone U.S.P. Tablets, 10 mg.

Economical

[illegible]onal indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

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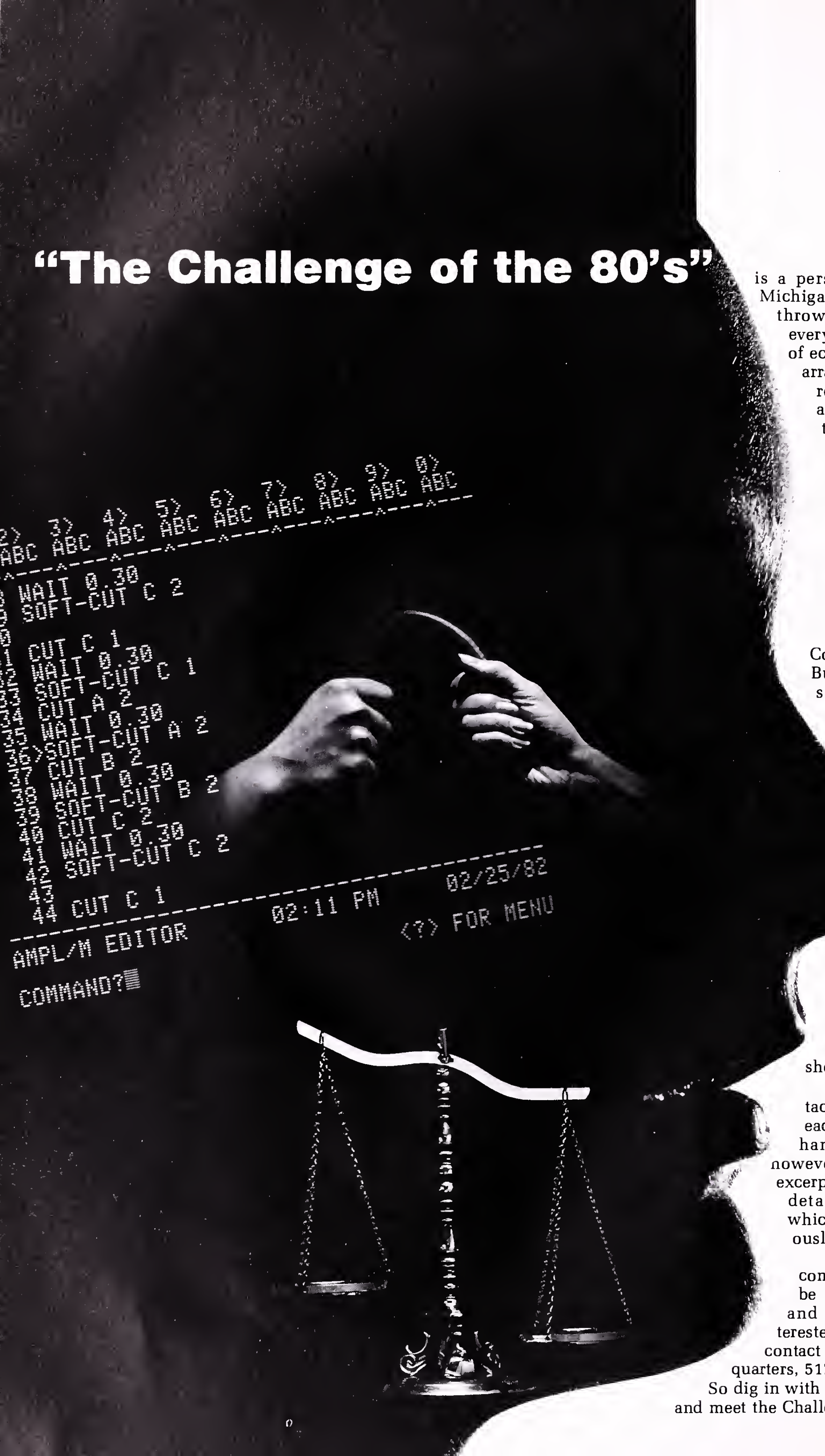
"The Challenge of the 80's"



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is a personal opportunity for every Michigan physician. The times have thrown the gauntlet down before every MD through a combination of economic changes, new practice arrangements, rearranged population balances and ever-new scientific and technologic possibilities. MSMS stands ready to help you take up that gauntlet and meet the challenges face to face.

MSMS begins a major new effort on the following pages to serve its members by providing the information and perspectives needed.

MSMS Public Service Committee Chairman Robert D. Burton, MD, Grand Rapids, describes the effort beginning next page. The current scene is set through excerpts from a recent speech delivered by MSMS President James H. Tisdel, MD. And then the first of a series of articles dealing directly with the communications, practice management, competition and ethics challenges of the 80s follows.

More articles in each of these areas will appear throughout 1982 in *Michigan Medicine*. Each will be keyed with its identifying logo, shown on the facing page.

Michigan physicians may detach this series of articles from each issue and compile them for a handy reference. Each article, however, will be a condensation or excerpt of a much longer and more detailed offering on the subject which is being written simultaneously.

These longer tracts will be compiled by MSMS in a manual to be printed at the end of the year and made available to every interested MSMS member. For details, contact Mert Scholten at MSMS headquarters, 517/337-1351.

So dig in with the next page, begin boning up and meet the Challenge of the 80s with MSMS!

"Meeting the challenge of the 80s" MSMS public relations focus for 1982

By Robert D. Burton, MD
Grand Rapids

Doctor Burton is chairman, MSMS Committee on Public Service.

Helping our members meet the economic and competitive challenges of practicing medicine in this decade will constitute the heart of the MSMS public relations program for 1982.

As physicians and members of the public service committee, we are aware of the problems faced by our members in today's economic and competitive climate. And we intend to create a tool to assist our members.

Members are target

"Meeting the Challenge of the 80s — A Guide to Successful Medical Practice" will be both the theme and the anticipated end product of our major activity for 1982.

The 1981 PR effort was aimed at the general public, outside of medicine. The 1982 effort is being aimed at our internal public, our members. Our effort is built on a conviction that unless we can help our members meet current problems, there will be little need for external public relations, regardless of scale.

We are pulling together expert sources — hard data as well as concepts with promise, to compile a sourcebook which our members may use as a guide to practicing medicine in today's climate.

Our intention is to publish at the end of 1982 a comprehensive guide to four areas of medical practice — financial management, ethical-legal issues, communications and competition.

Each section of the final product will provide help for achieving the greatest practice efficiency and effectiveness in the areas covered.

Members will not have to wait

until year's end to reap some benefit from this project, however. Beginning with this issue, *Michigan Medicine* will carry segments of this information in a series of monthly installments. Members are encouraged to save these articles and collate them into a continually enlarging reference manual of their own.

Symbols are keys

The front cover of this issue carries the four symbols to look for in identifying these special articles.

The video screen symbol will be used as the logo to head any articles dealing with practice management. Our plans are to include suggestions not only for those who may be just starting practice, but also for those who have been in practice for many years.

The scales of justice will be our logo for any articles dealing with the legal and ethical aspects of practice. Such things as the AMA and MSMS Judicial Commission rulings will be contained in this section along with portions of the medical practice act dealing with lawsuits, professional liability and a number of other matters.

The human profile symbol will be our logo for articles relating to communications.

And the fourth symbol, the two strong forearms tugging on a metal bar, connotes all forms of competition which will be affecting medical practice in the coming years. Our plans are to address the topic and show physicians different ways of meeting the competition successfully.

All future articles in this series will carry one of these symbols to help you identify the subject area and where it fits into the scheme of things.

This is an ambitious project, but an extremely important one. We welcome your reactions, comments and suggestions as we proceed.

Following is a general outline of the entire project.

Practice Management

Section I
Financial aspects
A. Incorporation
B. Group practice
C. Financial systems and controls
D. Fees, billing and collection
E. Lease or buy options
F. Consultants and how to use them

Section II
Staffing the professional office
A. Employee selection, motivation, management and termination
B. Policies, procedures and position descriptions
C. Physician/physician relationships
D. Physician/hospital relationships
E. Contracts and how to negotiate them

Section III
Office efficiency
A. Appointment scheduling
B. Medical recordkeeping
C. Office design
D. Computers and their applications
E. Purchasing policies and dealing with vendors

Section IV
A. Patient relations
B. Management style
C. Personal organization and time management
D. Setting goals
E. Retirement plans and investments
F. Your image in the community

Each section will have a brief introduction and an accompanying reading list.

Communications Section

Section I
Communicating with patients
A. Patient information brochures
B. Discussions with patients
C. Patient surveys
D. The medical assistant in patient contacts
E. A patient-oriented office design

Section II
Communicating with the public
A. Advertising your practice
B. Getting your name in the media
C. Community involvement

Section III
Intra-professional communications
A. Handling referrals
B. Hospital communications
C. Professional associations

Ethical/Legal Considerations

Section I
Legal aspects of medical practice
A. Choosing your attorney
B. Legal documents required

C. If you are subpoenaed
D. Handling lawsuits
E. Patient records
F. Third party payors
G. Confidentiality
H. Obtaining hospital privileges

Section II
Ethical matters in medical practice
A. The AMA Code of Ethics
B. MSMS Judicial Commission rulings
C. How to seek an ethics ruling

Section III
The Michigan Public Health Code
A. What the medical practice section provides
B. Legally required reports, actions and data
C. Using para-professional help in your practice

Professional Competition

Section I
Overview of the 80s
A. Physician supply
B. Consumer expectations
C. Impact of technology
D. Legislative and governmental influences
E. Economic factors

Section II
Sources of competition
A. Intra-specialty rivalries
B. Paramedical professions
C. HMOs, IPAs and mega-group practices

Section III
Marketing your services
A. Legal and ethical considerations
B. Analyzing the market potential
    1. Determining the size of your potential market
    2. Developing a statistical profile of your market
    3. Preparing a patient origin data base
    4. Establishing measurable goals
C. Preparing and placing advertising

Physicians must learn rudiments of effective management

(Excerpted from a section of the developing MSMS manual.)

The concept of physicians as managers is not new. But today the physician/manager is taking a new form.

Economic, legal and societal pressures are making the physician's managerial scheme into a participative rather than a dictatorial arrangement.

The evolution of paramedical personnel, new medical specialties, a highly litigious patient population, unionization of health care personnel, and a more competitive environment all are factors shaping the nature of physicians' relationships with colleagues and subordinates.

For some time now, industrial and commercial organizations have worked to guide interpersonal behavior of their employees and managers toward productive results. They would view with horror much interpersonal behavior that has been commonplace in the operating room and hospital ward.

How then is the MD, with boundless time, intellect and energy invested in becoming a skilled medical practitioner, to become competent in the management skills that others spend years in acquiring?

The answer is that you must invest some time, intellect and energy in learning the rudiments of effective management.

Although most successful managers consider they have a highly personalized style, there are certain similarities about them that can be emulated if you want to become a good manager.

The first thing all good managers have in common is that they are goal-oriented. They are aware of the people and equipment that are required to accomplish their goals and are willing to take the necessary steps to insure that both are responsive to the tasks required of them. They are orderly in their thinking, confident in their ability, objective in their relationships, and approachable by those who work with them.

Management theorists such as Maslow and McGregor have refined the practice of management and have generated a huge following of social scientists whose writings occupy great sections of our libraries. For the busy physician, intensive research into the esoterica of management theory holds little appeal. Suffice it to say that most of today's management experts have been influenced by Douglas McGregor's Theory X and Theory Y concepts of management style.

Theory X type managers feel the average person hates work and will avoid doing it, prefers to be directed, dislikes responsibility, has little ambition and wants security above all. Obviously, the best management style in that case is one that involves control, coercion and threat of punishment.

Theory Y is that physical and mental effort are a natural part of our make-up; and self-control toward both will be exercised by persons who understand the objectives of their work and have made a commitment to them.

Rensis Likert expanded on this approach by listing four systems that might be applied by a manager. System 1 involves an authoritative approach that is exploitive; System 2 is a benevolent authoritarianism; System 3 uses a consultative concept; and System 4 is the participative group approach.

In many ways, the practice of medicine has been carried out in a Theory X environment based on the authority of the physician's training and skills. Today, however, legal, social and economic structures that affect the delivery of medical care have made it imperative that the physician accept a position as member of a health care delivery team.

The team approach would be categorized by Likert as a System 4, participatory management scheme. Such a scheme implies that staff members will be involved in making the decisions that affect their work. Studies have shown that staff members who participate in management decisions feel more highly motivated and committed to the organization's goals.

In the professional environment, there are some obvious restrictions that apply to the participatory management concept:

- One segment of the staff may not make decisions that affect the work of another segment or which impinge on the technical expertise of another segment.
- Evaluation of the competence and performance of staff in their areas of expertise is not included in the scheme.
- Decisions affecting spending may be made only by, or with the concurrence of, the group to whom the funds are allocated.

The basic rule for participatory decision-making is that it is restricted to persons with the understanding and knowledge required to contribute to the decision.

It should be remembered that the essence of good management is communication. You should understand and be competent in the practice of effective communications techniques. You will find that establishing good communications with your staff will pay significant dividends.

Understand the process by which communication occurs: professionals describe steps called ideation, encoding, transmission, reception, decoding, action and feedback. Remember that communication even between friends is difficult, and at times impossible, because of the many barriers that exist in our society.

For this reason, it is imperative that the physician-manager set up a means for improving feedback from colleagues and subordinates as well as for developing their skill in listening. The keys to effective communication are sincerity, understanding human needs, and choosing the proper channels and media for communicating.

Sincerity is most often put to the test in cases where nonverbal behavior does not coincide with the message conveyed in face-to-face communication. Normally this occurs in situations where the person sending the message is unwilling to share all of the information desired by those receiving the message. Obviously, such messages are better conveyed by print or electronic media, if at all.

Understanding human needs is a key element in communicating any message. This is important to remember in dealing with both patients and colleagues in time of crisis. A careful evaluation of the circumstances before communicating to those involved will often avoid embarrassment or hostile reaction.

Be aware of the barriers that may impede your attempt to communicate:

- The receiver's inability and unwillingness to accept the message.
- Lack of identity and credibility of the sender.
- The varied perception of sender and receiver concerning the nature of the situation.
- The inacceptability by the receiver of the medium chosen to convey the message.

Choosing the proper communications medium and channel is often the deciding factor in the success or failure of your effort to communicate.

Experienced managers know that there are formal and informal channels by which information may be transmitted. Formal communication occurs within the established lines of authority of your organization; while informal communication usually results in the social environment outside the formal structure of your organization.

Put another way, it's the difference between a notice posted on the office bulletin board and a tidbit of gossip plucked from the office grapevine.

It is worth your while to recognize that both channels have their uses in effective management. Politicians have long understood and used the "leak" as a means of communicating sensitive messages; you will do well to learn this technique.

Equally important as the channel of communication is the medium that is used to carry the message. This subject is far too extensive for proper consideration here: but before making your choice, consider such things as the speed required, the need for feedback, and the level of acceptance that the medium has with the audience. A radio broadcast would not be the appropriate communications medium for an audience of deaf persons; neither would an editorial in a newsletter reach an employee who routinely threw the publication in the wastebasket unread.

Newsletters, notices posted on the bulletin board, procedure manuals, meetings, one-on-one discussions and a broad spectrum of other communications media are all tools that you as physician-manager should be prepared to use. Your ability as a manager will be judged to great degree on the efficacy of your communications with colleagues and subordinates.

In summary, the physician today is required to be a manager of people and resources, and the wise physician will expend some effort to learn the basics of effective management. You should be aware that autocratic management styles are considered by the experts to be counterproductive and that participatory management will require an understanding of and competency in good communications practice.

The investment of time and study that may be required will be well compensated in the highly competitive practice environment that is just around the corner.

Setting the scene: Today's complicated medical practice

There are good reasons for a major new MSMS effort to help Michigan physicians compete successfully.

Michigan physicians face a host of challenges unique to our state's economic and social structures. These situations are complicated, and it looks as though they will be sticking around for awhile.

MSMS has identified and is at work on many of these problems. Medical society leaders and staff are giving this effort high priority, to help today's doctors enjoy successful and rewarding professional lives, and to ensure an inviting climate for our physicians-in-training.

Here are some characteristics of medical practice in Michigan which Michigan physicians must learn to manage during this decade.

Competition

There is every reason to believe that medicine will become more competitive in the next 10 years, for several reasons in various ways.

The GMENAC report — a comprehensive government and professional study — predicts a surplus of 70,000 physicians by 1990 and an excess of 100,000 by the year 2000. How accurate these predictions are is difficult to determine. But with the number of medical school graduates now exceeding 15,000 per year, there is no question we are headed for some kind of surplus. Certain specialties particularly are going to be seeing excess numbers and keener competition for patients.

Ironically, however, there still will be maldistribution problems in some areas.

These projected surpluses mean the physician's average work week, now about 56 hours, probably will be shortened to about 40 hours. Reduced workloads will mean reduced incomes, as it is unlikely increased procedures or higher fees will make up the difference, even if they should be tolerated by patients and third party payors.

Slower population growth likewise will add to the situation, as more doctors compete for fewer patients.

As the expected surplus of physicians develops we can anticipate greater concern with patient retention. Data just in for the past year indicates a 13 percent drop in office calls nationwide with the bulk of it coming in the industrial north.

If this trend continues we can

see physicians expanding their scope of practice to maintain income. At the same time, we are apt to have the rudiments of inter-specialty confrontations as expanded practices cut down on referrals to other specialties.

On the positive side, the predicted doctor surplus means the migration of medical care providers to the underserved areas of the state and nation. It also means a potentially reduced work week for physicians.

Economics

If the Michigan economy continues sluggish, we can anticipate continued unemployment and increased Medicaid numbers, unless substantial numbers of recipients move elsewhere. Experience is already indicating the young, the educated and the skilled are finding and accepting jobs outside of Michigan, particularly in the sun belt states. The unskilled, uneducated, less mobile and elderly will by and large remain where they are. Thus our Medicaid and Medicare populations will likely increase while the economic base of support grows smaller.

Another complication is that the federal government may take over the states' Medicaid programs, as President Reagan is proposing. It is likely then, that there will be national reimbursement standards. This may mean that Michigan MDs will be paid for fewer numbers and types of services.

This may bolster current trends toward tighter utilization controls. Likewise, we can expect an increasing amount of educational efforts directed at preventative medical care and increased emphasis on healthful living. The irony is that many of the low income Medicaid recipients will be among those least able to afford proper nutrition, shelter and those necessities which help them live healthful lives.

It is likely that we will see the advent of more co-pay and cost-sharing programs, not only in private sector third party programs, but in governmental programs as well. Asking each patient to pay even a $1 charge for each office visit or medical service rendered might make them more judicious in their use of the service.

And what will be done to curb provider abuses of the system? We will probably see a trend toward systems which put the doctor at risk. One way might be toward capitation systems where for a certain number of dollars per patient the doctor is given responsibility for the health care of a given number of patients and is expected to keep them out of the hospital as much as possible. This of course, could open a whole new era of hospital competition for patients (and doctors), with its own set of problems.

As signposts in this journey through economic geography we can look for further development of skilled nursing facilities, greater use of outpatient facilities and other means of confronting the high costs of hospitalization.

Not only is the state's economy a problem for Michigan doctors, but the fact that medicine is in a growth period of new procedures, drugs and biomechanics adds further to the double digit inflation. Without any advances in medicine whatsoever, costs continue to rise. Add to inflation the cost of new technology and the financial impact is staggering. Never before have we been able to do so much for so many patients. But we may have reached the point where we cannot afford more.

Physicians' share

You can bet that physicians will face continuing pressure for practicing cost effective medicine. We'll be seeing more protocols for specific ailments; more pre-admission testing; more utilization review; more second opinion programs and more peer review activity.

It may become harder and harder for doctors to get full staff privileges at full occupancy hospitals.

Blue Cross Blue Shield of Michigan will undoubtedly become more competitive with other third party payors. As BCBSM develops its cost-containment programs, we shall have to proceed cautiously in our pronouncements, emphasizing quality health care as needing X number of dollars.

We also can expect that BCBSM will concentrate on appropriate use of services, and perhaps seek to limit payment to fully participating doctors. What impact this will have on the number of physicians is anybody's guess.

We can fully anticipate the rationing of health care in Michigan. The rationing could be of two kinds: caps on monies spent and on the availability of services and planning. In all likelihood, we will see some combination of the two.

Nationally, there may not be any greater percent of the Gross National Product available to medicine. The absolute dollars will rise, of course, but medicine's proportion of the GNP has held steady at approximately 10 percent.

While physician gross income is rising at about the same percentage as inflation if it's going up at all, a number of physicians are seeing net incomes rise due to greater practice efficiency. If nothing else, today's economic climate is forcing physicians to become better businessmen.

The moral of the story is clear — physicians will have to be involved as never before in the health planning process, in the legislative process and in the patient relations/public relations aspects of medical practice.

This article was developed from a speech delivered recently by MSMS President-elect James H. Tisdel, MD.

Pfizer Laboratories
Announces

THE FIRST ORAL
CALCIUM CHANNEL
BLOCKER
FOR THE
MANAGEMENT OF
ANGINA PECTORIS

NEW
PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

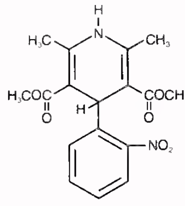
Please see PROCARDIA® *prescribing information on next page.*

PROCARDIA® CAPSULES

For Oral Use

Nifedipine

DESCRIPTION: PROCARDIA (nifedipine) is an antianginal drug belonging to a new class of pharmacological agents, the calcium channel blockers. Nifedipine is 3,5-pyridinedicarboxylic acid, 1,4-dihydro-2,6-dimethyl-4-(2-nitrophenyl)-, dimethyl ester, $C_{17}H_{18}N_2O_6$, and has the structural formula:



Nifedipine is a yellow crystalline substance, practically insoluble in water but soluble in ethanol. It has a molecular weight of 346.3. PROCARDIA CAPSULES are formulated as soft gelatin capsules for oral administration each containing 10 mg nifedipine.

CLINICAL PHARMACOLOGY: PROCARDIA (nifedipine) is a calcium ion influx inhibitor (slow channel blocker or calcium ion antagonist) and inhibits the transmembrane influx of calcium ions into cardiac muscle and smooth muscle. The contractile processes of cardiac muscle and vascular smooth muscle are dependent upon the movement of extracellular calcium ions into these cells through specific ion channels. PROCARDIA selectively inhibits calcium ion influx across the cell membrane of cardiac muscle and vascular smooth muscle without changing serum calcium concentrations.

Mechanism of Action: The precise means by which this inhibition relieves angina has not been fully determined, but includes at least the following two mechanisms:

1) Relaxation and prevention of coronary artery spasm: PROCARDIA dilates the main coronary arteries and coronary arterioles, both in normal and ischemic regions, and is a potent inhibitor of coronary artery spasm, whether spontaneous or ergonovine-induced. This property increases myocardial oxygen delivery in patients with coronary artery spasm, and is responsible for the effectiveness of PROCARDIA in vasospastic (Prinzmetal's or variant) angina. Whether this effect plays any role in classical angina is not clear, but studies of exercise tolerance have not shown an increase in the maximum exercise rate-pressure product, a widely accepted measure of oxygen utilization. This suggests that, in general, relief of spasm or dilation of coronary arteries is not an important factor in classical angina.

2) Reduction of oxygen utilization: PROCARDIA regularly reduces arterial pressure at rest and at a given level of exercise by dilating peripheral arterioles and reducing the total peripheral resistance (afterload) against which the heart works. This unloading of the heart reduces myocardial energy consumption and oxygen requirements and probably accounts for the effectiveness of PROCARDIA in chronic stable angina.

Pharmacokinetics and Metabolism: PROCARDIA is rapidly and fully absorbed after oral administration. The drug is detectable in serum 10 minutes after oral administration, and peak blood levels occur in approximately 30 minutes. It is highly bound by serum proteins. PROCARDIA is extensively converted to inactive metabolites and approximately 80% of PROCARDIA and metabolites are eliminated via the kidneys. The half-life of nifedipine in plasma is approximately two hours. There is no information on the effects of renal or hepatic impairment on excretion or metabolism of PROCARDIA.

Hemodynamics: Like other slow channel blockers, PROCARDIA exerts a negative inotropic effect on isolated myocardial tissue. This is rarely, if ever, seen in intact animals or man, probably because of reflex responses to its vasodilating effects. In man, PROCARDIA causes decreased peripheral vascular resistance and a fall in systolic and diastolic pressure, usually modest (5–10 mm Hg systolic), but sometimes larger. There is usually a small increase in heart rate, a reflex response to vasodilation. Measurements of cardiac function in patients with normal ventricular function have generally found a small increase in cardiac index without major effects on ejection fraction, left ventricular end diastolic pressure (LVEDP) or volume (LVEDV). In patients with impaired ventricular function, most acute studies have shown some increase in ejection fraction and reduction in left ventricular filling pressure.

Electrophysiologic Effects: Although, like other members of its class, PROCARDIA decreases sinoatrial node function and atrioventricular conduction in isolated myocardial preparations, such effects have not been seen in studies in intact animals or in man. In formal electrophysiologic studies, predominantly in patients with normal conduction systems, PROCARDIA has had no tendency to prolong atrioventricular conduction, prolong sinus node recovery time, or slow sinus rate.

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta-blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure since severe hypotension can occur from the combined effects of the drugs. See Warnings.

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Increased Angina/Beta Blocker Withdrawal: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of PROCARDIA would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. See Warnings.

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents: See Indications and Warnings. Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Carcinogenesis, mutagenesis, impairment of fertility: Nifedipine was administered orally to rats for two years and was not shown to be carcinogenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. In vivo mutagenicity studies were negative.

Pregnancy: Pregnancy category C. Nifedipine has been shown to be teratogenic in rats when given in doses 30 times the maximum recommended human dose. Nifedipine was embryotoxic (increased fetal resorptions, decreased fetal weight, increased stunted forms, increased fetal deaths, decreased neonatal survival) in rats, mice and rabbits at doses of from 3 to 10 times the maximum recommended human dose. In pregnant monkeys, doses 2/3 and twice the maximum recommended human dose resulted in small placentas and underdeveloped chorionic villi. In rats, doses three times the maximum human dose and higher caused prolongation of pregnancy. There are no adequate and well-controlled studies in pregnant women. PROCARDIA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

ADVERSE REACTIONS: In multiple-dose U.S. and foreign-controlled studies in which adverse reactions were reported spontaneously, adverse effects were frequent but generally not serious and rarely required discontinuation of therapy or dosage adjustment. Most were expected consequences of the vasodilator effects of PROCARDIA.

Adverse Effect	PROCARDIA (%) (N = 226)	Placebo (%) (N = 235)
Dizziness, light-headedness, giddiness	27	15
Flushing, heat sensation	25	8
Headache	23	20
Weakness	12	10
Nausea, heartburn	11	8
Muscle cramps, tremor	8	3
Peripheral edema	7	1
Nervousness, mood changes	7	4
Palpitation	7	5
Dyspnea, cough, wheezing	6	3
Nasal congestion, sore throat	6	8

There is also a large uncontrolled experience in over 2100 patients in the United States. Most of the patients had vasospastic or resistant angina pectoris, and about half had concomitant treatment with beta-adrenergic blocking agents. The most common adverse events were the same ones seen in the controlled trials, with dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

Several of these side effects appear to be dose related. Peripheral edema occurred in about one in 25 patients at doses less than 60 mg per day and in about one patient in eight at 120 mg per day or more. Transient hypotension, generally of mild to moderate severity and seldom requiring discontinuation of therapy, occurred in one of 50 patients at less than 60 mg per day and in one of 20 patients at 120 mg per day or more.

In addition, 2% or fewer of patients reported the following: Respiratory: Nasal and chest congestion, shortness of breath. Gastrointestinal: Diarrhea, constipation, cramps, flatulence. Musculoskeletal: Inflammation, joint stiffness, muscle cramps. CNS: Shakiness, nervousness, jitteriness, sleep disturbances, blurred vision, difficulties in balance. Other: Dermatitis, pruritus, urticaria, fever, sweating, chills, sexual difficulties.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

In a subgroup of over 1000 patients receiving PROCARDIA with concomitant beta blocker therapy, the pattern and incidence of adverse experiences was not different from that of the entire group of PROCARDIA treated patients (see Precautions).

In a subgroup of patients with a diagnosis of congestive heart failure as well as angina, dizziness or light-headedness, peripheral edema, headache or flushing each occurred in one in eight patients. Hypotension occurred in about one in 20 patients. Syncope occurred in approximately one patient in 250. Myocardial infarction or symptoms of congestive heart failure each occurred in about one patient in 15. Atrial or ventricular dysrhythmias each occurred in about one patient in 150.

Laboratory tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have already been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

OVERDOSAGE: Although there is no well documented experience with PROCARDIA overdosage, available data suggest that gross overdosage could result in excessive peripheral vasodilation with subsequent marked and probably prolonged systemic hypotension. Clinically significant hypotension due to PROCARDIA overdosage calls for active cardiovascular support including monitoring of cardiac and respiratory function, elevation of extremities, and attention to circulating fluid volume and urine output. A vasoconstrictor (such as norepinephrine) may be helpful in restoring vascular tone and blood pressure, provided that there is no contraindication to its use. Clearance of PROCARDIA would be expected to be prolonged in patients with impaired liver function. Since PROCARDIA is highly protein-bound, dialysis is not likely to be of benefit.

DOSAGE AND ADMINISTRATION: The dosage of PROCARDIA needed to suppress angina and that can be tolerated by the patient must be established by titration. Excessive doses can result in hypotension.

The starting dose is one 10 mg capsule, swallowed whole, 3 times/day. The usual effective dose range is 10–20 mg three times daily. Some patients, especially those with evidence of coronary artery spasm, respond only to higher doses, more frequent administration, or both. In such patients, doses of 20–30 mg three or four times daily may be effective. Doses-above 120 mg daily are rarely necessary. More than 180 mg per day is not recommended.

In most cases, PROCARDIA titration should proceed over a 7–14 day period so that the physician can assess the response to each dose level and monitor the blood pressure before proceeding to higher doses.

If symptoms so warrant, titration may proceed more rapidly provided that the patient is assessed frequently. Based on the patient's physical activity level, attack frequency, and sublingual nitroglycerin consumption, the dose of PROCARDIA may be increased from 10 mg t.i.d. to 20 mg t.i.d. and then to 30 mg t.i.d. over a three-day period.

In hospitalized patients under close observation, the dose may be increased in 10 mg increments over four to six-hour periods as required to control pain and arrhythmias due to ischemia. A single dose should rarely exceed 30 mg.

No "rebound effect" has been observed upon discontinuation of PROCARDIA. However, if discontinuation of PROCARDIA is necessary, sound clinical practice suggests that the dosage should be decreased gradually with close physician supervision.

Co-Administration with Other Antianginal Drugs: Sublingual nitroglycerin may be taken as required for the control of acute manifestations of angina, particularly during PROCARDIA titration. See Precautions, Drug Interactions for information on co-administration of PROCARDIA with beta blockers or long-acting nitrates.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA Capsule contains 10 mg of nifedipine. PROCARDIA Capsules are supplied in amber glass bottles of 100 capsules (NDC 0069-2600-66).

The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

Issued January 1982

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AMA Auxiliary head to appear at MSMS/A convention

By Barbara Grennan
Muskegon

The MSMS Auxiliary Convention this year will be held in Grand Rapids at the Amway Grand Plaza Hotel. Dates for this annual meeting are May 3, 4, 5, 1982.

Special guest for this year's convention will be the American Medical Association Auxiliary President Isobel Dvorsky, San Leandro, CA. Mrs. Dvorsky is a San Leandro city commissioner for parks and recreation and serves on a special city task force for parks and recreation. She was born in Chicago, and holds a BA in speech pathology from the University of Iowa. Until assuming the AMA Auxiliary presidency, she was a speech pathologist in the public schools of San Leandro.

Isobel is a past president of the California auxiliary and was active in beginning Project Re-Entry, a program for stroke victims and Project LEARN, a program for children with learning disabilities. She has been a member of the AMA Auxiliary Board of Directors since 1975 and has been active on the Project Bank and Long Range Planning Committees, as well as serving as western regional and first vice president.

Mrs. Dvorsky spoke on "new opportunities for volunteerism" to the AMA House of Delegates at its interim meeting in December. She told delegates that in order to serve the needs of the nation's people who would suffer from the cutbacks in government spending, there would have to be a return to volunteerism. Mrs. Dvorsky also moderated a panel discussion of Volunteerism at the AMA Leadership Meeting in February.

Isobel Dvorsky's presence at the MSMS/A Convention will be a decided plus for state auxiliary members. Your attendance and participation is invited.

Mrs. Grennan is MSMS/A president

ELECTIONS '82

In the upcoming 1982 elections Michigan voters will elect a Governor, a U.S. Senator, 18 Congressmen, 38 Michigan State Senators and 110 State Representatives

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MSMS position statement parallels GMENAC projections

By Kenneth J. Ray, MD
Trenton

On January 27, The Council adopted a position on the report of the Graduate Medical Education National Advisory Committee (GMENAC). The controversial GMENAC Report, predicted a national surplus of physicians by 1990 and made 107 recommendations on how to minimize the surplus.

To understand the GMENAC Report, one must assess the basic elements of the GMENAC study — future physician supply and future physician need. Future physician supply, at least for the next two decades, is relatively easy to predict. It is similar to constructing a life table. Therefore, the figures for physician supply are considered reliable.

The future "need" for physicians is much more difficult to quantify.

There is no agreement on how many physicians are necessary today when the capabilities of the health care delivery system are known. It is much more difficult to predict future need when the capabilities of the health care delivery system are unknown. Compounding this problem is the fact that GMENAC made predictions for physician need by specialty.

MSMS did not accept the GMENAC specialty predictions, but did agree that the GMENAC prediction for future aggregate physician need provided an adequate number of physicians to meet the health care needs of the country given the current state of medical science. Therefore, the GMENAC projection for aggregate physician need (one physician per 497-551 persons) was accepted with the caveat that physician need must be constantly reevaluated

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Doctor Ray is chairman, MSMS Steering Committee on Health Planning.

MSMS statement on GMENAC

MSMS agrees that the GMENAC guideline of one physician per 497-551 persons provides an adequate number of physicians to meet patients' health care needs and, therefore, that there will be a "surplus" of physicians in Michigan in the future.

This statement must be considered with the following caveats:

A. A "surplus" is not assumed to be detrimental to the health care delivery system. However, an unlimited increase in the number of physicians will be detrimental to the health care delivery system.

B. MSMS finds that GMENAC physician/population ratio of 1:497-551 as an acceptable *guideline*. MSMS does not feel that this ratio is adequate for use as a rigid parameter to govern physician supply.

C. MSMS does not take a position on the individual specialty ratios that comprise the overall ratio. The specialty ratios are highly subjective and disputed by the various specialty organizations.

D. MSMS feels that, although a physician "surplus" may exist in the aggregate, geographic and specialty maldistribution will still result in limited access to a physician for some segments of the nation as well as the state.

E. Agreement with the guideline of one physician per 497-551 persons is based on a trade-off between access to care concerns and cost containment concerns. Policy makers must address the cost-access tradeoffs and adopt a coherent physician manpower policy.

Conclusion:

MSMS projects that the Michigan active physician/population ratio, which is currently about 1:600, will approach 1:450 in 1990, thereby creating a physician "surplus". While MSMS feels it is appropriate to take action to decrease this surplus, any such actions must be undertaken cautiously and should be moderated by the following conditions:

1. The effects of a physician "surplus" should be evaluated from a public policy perspective.

2. The changes in the pattern of new Michigan licensees due to reductions in foreign born FMGs, the unknown increase in US FMGs, and the effects of Michigan's business climate on the retention of physicians should be observed and understood.

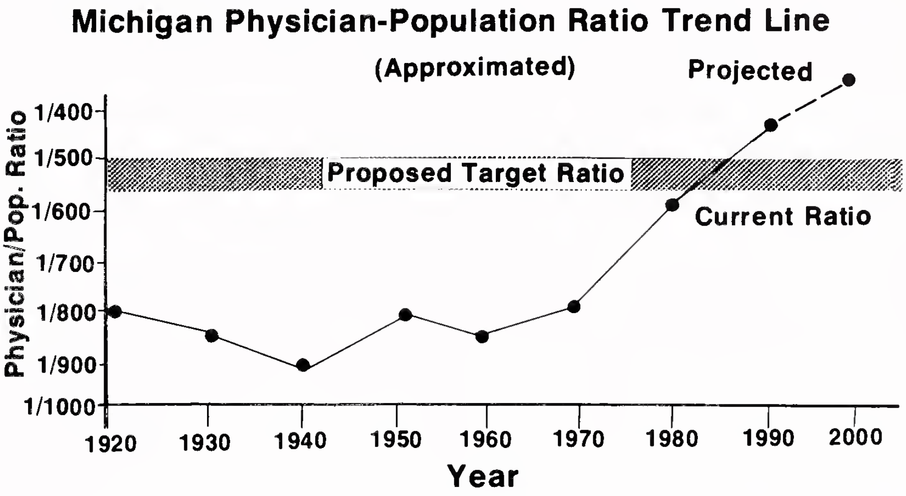
3. Physician distribution is a social problem of equal consequence to the issue of physician "surplus". A coherent public policy that addresses the issues of cost containment and access to care should be developed to guide medical education.

4. Because of the subjective nature of health manpower projections, any health manpower policy must be periodically re-evaluated.

due to the rapid evolution of medical knowledge.

What will the coming national physician surplus mean to Michigan? The graphic representation illustrates the enormous growth in the physician population that is predicted for our state. The 1:600 physician to population ratio of 1980 will close to a ratio of 1:450 in 1990 and will approach 1:400 by the year 2000. During this decade, we will achieve and surpass the GMENAC proposed ratio of one physician per 497-551 persons.

This fact has great significance for the individual physician as well as for organized medicine. For the individual physician, it means greater competition in the future. This will cause some physicians to become more innovative in their practice styles in order to attract adequate patient loads, and will cause other physicians to escape the direct economic competition by seeking salaried positions or other mechanisms to guarantee a patient load.


Michigan Physician-Population Ratio Trend Line

(Approximated)

For organized medicine, a physician surplus represents a new set of social challenges. Most of the current policy regarding physician manpower is based on the assumption of a physician shortage. A condition of physician surplus will necessitate a rethinking of many policies. This may have far-reaching ramifications for medical education, graduate medical education and physician licensure programs.

There are many weaknesses in the GMENAC methodology. In many crucial areas it offers only a "best guess" of coming events. Despite its limitations, however, GMENAC is the best work currently available to predict future physician supply and need.

Its greatest danger lies in the possibility that its findings will be blindly accepted in future years instead of being constantly rechallenged for validity.

Are the results of
$100 million worth of
government-funded research
on hypertension
worth reading about?

ISSUES AND ANGLES

Variety of views exist about a Michigan physician surplus

Background

The 1970's was the decade in which new medical schools were built, class sizes increased, and funding escalated, all with the backing of the state and federal government. This expansion was the result of studies in the late 1960's stating that a physician shortage existed.

But the movement to cut enrollments started in 1978 when Joseph Califano, Secretary of Health, Education and Welfare, stated that an oversupply of physicians leads to an unnecessary increase in health care expenditures.

Last year, a major national study by the Graduate Medical Education National Advisory Committee (GMENAC) concluded that far too many physicians were being trained for future demand. The study said that the ratio of physicians to population should be 1:497-551. In 1978, that ratio was 1:585. But projected for 1990, the ratio is 1:455 and for the year 2000, 1:405.

In Michigan, two studies were produced concerning future physician supply. Last April, a report by the Public Sector Consultants for Senator Bill Huffman concluded that the enrollment levels of the four medical schools should be maintained at their current level of 700 students.

In May, the Office of Health and Medical Affairs released a study with results similar to the GMENAC report. The OHMA study said that under one set of assumptions, by 1990 the supply of physicians would exceed demand by 46 percent.

Now, the MSMS Council has produced its own position statement, agreeing with the GMENAC predictions for an oversupply of physicians, and with the GMENAC figures for the optimum physician/patient ratio.

The MSMS Council also recommended two major methods by which Michigan can curtail physician production: the licensing procedure and medical school enrollments.

The Council adopted policy that only graduates of medical schools meeting standards of the Liaison Committee for Medical Education automatically are eligible for licensure as Michigan MDs.

The Council supported the concept of enrollment reductions in Michigan's four medical schools, with the understanding that any future enrollment increases must be offered first to the schools which decreased numbers, until their former numbers are obtained.

(For the full MSMS statement on the GMENAC report, please see page 144.)

The issue

Will there be too many physicians in Michigan?

Not too long ago, it would have been heresy to ask that question, let alone answer yes.

But no longer. A growing number of health care experts believe that both the state and the nation are headed for a surplus of physicians. And they are looking for remedies to stabilize the numbers. One famous national study predicted by 1990 70,000 more physicians than required to provide physician services.

Although there is a consensus that a surplus will eventually occur in Michigan, there is disagreement as to whether such a surplus would be good or bad. Nevertheless, there is a strong movement to cut the numbers of Michigan physicians by cutting class enrollments at the state's four medical schools.

Last October, after negotiations with the state's Office of Health and Medical Affairs, the medical school deans issued a report detailing the enrollment cutbacks they could absorb. The deans, however, stated that the report "is not offered as support of state or national reports regarding physician surplus. The Council considers any prediction of physician surplus to be difficult to substantiate."

The proposed cutbacks are:

- University of Michigan Medical School: 25 percent decrease, or 60 students.
- Wayne State University Medical School: 12.5 percent decrease, or 32 students.
- Michigan State University College of Human Medicine: To hold its present class size.
- MSU College of Osteopathic Medicine: To hold its present class size.

Both of the latter two schools had planned to increase enrollments by nine percent.

Against cutbacks

There are generally two major views opposing cutbacks at medical schools.

One is that studies projecting future supply and demand are merely a science of assumptions. Therefore, plugging in different assumptions leads to different conclusions.

Although the GMENAC study is considered pretty reliable, the two Michigan studies disagree with each other. The Huffman study argues that class enrollments should remain the same. It claims that the flow of foreign medical graduates will decrease, that many doctors from in-state and out-state medical schools will not seek employment practices here because of the weak and uncertain economy.

The second view is less about cuts and more about whether a surplus could be cured by some other method. For example, an excess of physicians in major cities may lead some doctors to seek employment in areas where a shortage exists.

MSMS also argues against the notion that a surplus is necessarily wrong. "If competition is to become the regulator of the health care delivery system, a physician 'surplus' may benefit the consumer by improving access to services and keeping charges low."

For cutbacks

OHMA disagrees with the above views.

Its study points out that state expense to train medical students is high, (about $30,000 a year per student, most public supported) and that a physician once in practice adds another $350,000 a year from various services ordered for patients. In addition, the report maintains that "An increase in physician supply is unlikely to rectify the problems of geographic or specialty maldistribution. If each doctor has fewer patients, each patient is likely to receive more services."

In the last year there have been a number of articles about towns and cities where an excess of physicians practice. San Francisco is struggling with the problem and doctors there, especially those setting up new practices, are faced with underemployment, competition for referrals and sometimes moonlighting. Also, fees have increased and appointment times have decreased.

The OHMA report also states more physicians will not significantly improve the general public's health status.

Even the medical deans' report agrees in part, "because physicians are responsible for the major decisions which lead to health expenditures, and because other means for controlling the increased cost of health and medical care have not been entirely successful . . ."

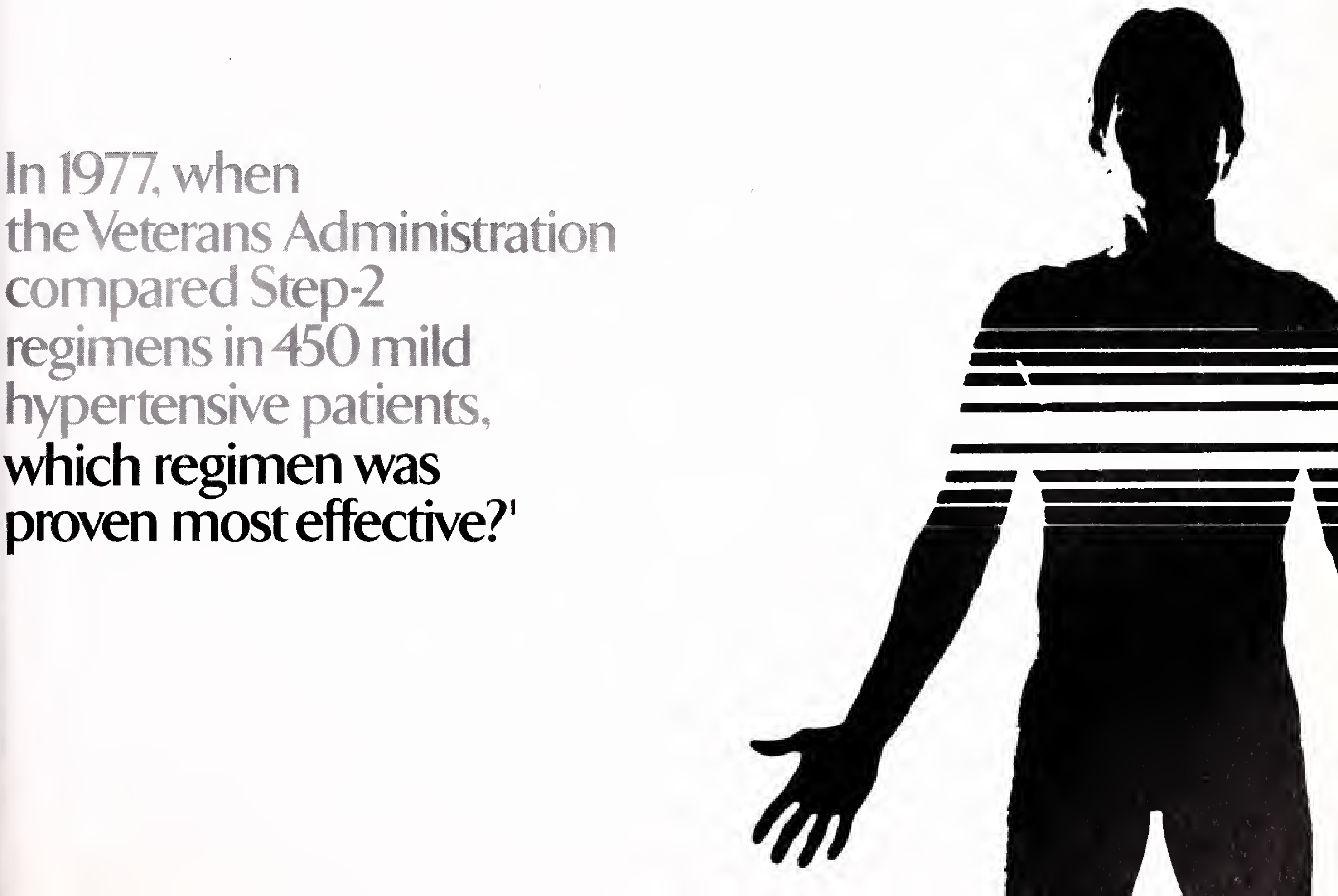
Outcome

The medical schools face two issues when the House and Senate appropriations committees take up the state budget next summer.

One is the number of students to be cut. There is, of course, no state mandate that forces medical schools to cut enrollments. But the state holds the purse strings. The deans have proposed an overall decrease of 14 percent, and OHMA has been talking about a 25 percent cut in students. But OHMA has been using that figure as a negotiation tactic and not as a final figure. Compromise will probably favor the medical schools.

And the legislature will find that cutting student enrollments is a lot easier as the effects are not felt until the late 80's. In addition, if MSMS supports student cuts, debate will center around how many students, and not on whether it should be done.

The second issue is the amount of funding for the medical schools. They don't want it cut — the money used to train those students — because they believe they have been already underfunded for so many years. But that issue depends in large part on the state economy and therefore the state budget, especially Medicaid.



Here are common elements of health care competition bills

By Deborah Zannoth
East Lansing

EDITORS NOTE: The following information was gathered by MSMS staff member Deborah Zannoth during her recent attendance at "The Age of Competition in Health Care," a Jan. 9-10 conference in Washington, DC, sponsored by the American Association of Foundations for Medical Care, the association of physician-sponsored-health plans.

Most Americans feel health care costs in the US are increasing at an alarming rate. And Congress has responded most often in recent years with economic regulations. These have included Health Systems Agencies and the certificate of need process, PSROs to review the appropriateness of hospital care financed through Medicare and Medicaid, limits on physician fees under Medicare and Medicaid, hospital rate setting and budget review programs in some states, as well as a three-year attempt of the Carter Administration to impose caps on hospital spending.

However, many free-market supporters agree these measures have not curtailed the rising costs but in some instances actually have increased costs to health consumers. What is needed, they contend, is a complete restructuring of the American health system toward greater competition. Therefore, many individuals feel one solution to the problem is through a redefinition of health benefits and how they relate to the tax structure.

The Bureau of Economics will present a future article with reactions and viewpoints from various individuals in the medical care arena.

The advocates of the pro-competition strategy recommend major changes in employment-based health benefit programs and in the overall tax treatment of such benefits. They support legislation that would eliminate much of the present regulation in the health industry and rely instead on competitive forces to produce an economical and efficient health care system.

In an effort to inform MSMS members, the MSMS Bureau of Economics here lists several elements common to the pro-competition proposals, as outlined in a report prepared by the Library of Congress Congressional Research Service. We hope this list will help members sort one plan's proponents from another.

Most pro-competition proposals would:

- **Limit the employer contribution to a maximum amount.** One of the elements contained in pro-competition proposals places a limit or cap on the amount an employer could contribute toward the premium cost of a health plan. Contributions in excess of that limit would be included in the employee's gross taxable income.
- **Require a choice of plans and an equal employer dollar contribution to each.** Another element of pro-competition proposals is a requirement that the employer offer a choice of plans or plan options, with an equal dollar contribution by the employer to each plan or option offered. Presently, the majority of employers offers a single insurance plan to their employees, or at best, a dual choice between a single plan or a health maintenance organization. In addition, many pro-competition proposals provide financial incentives for employees to choose lower cost health plans or options. The incentives would take the form of rebates to the employees who select lower cost coverages.
- **Require plans to contain cost-sharing features.** Patient cost-sharing could include *deductibles*, which are the dollar amounts the patient must pay initially before the insurer will assume any liability for the remaining covered services; *coinsurance*, or a percentage of the eligible expenses for which the patient is liable; and *copayments*, or flat dollar amounts required per unit of service or unit of time.
- **Repeal the tax deduction for health insurance premiums.** The health insurance premium tax deduction allows taxpayers to deduct one-half of their health insurance premiums, up to a limit of $150. This deduction is a tax subsidy designed in part as an incentive for the purchase of health insurance.
- **Include employer contributions as employee income.** The exclusion of employer health contributions from employees' taxable income provides a considerable incentive for employees to bargain for, and for employers to offer, more health benefits coverage. It has been argued by the pro-competition advocates that the exclusion thus encourages employees to purchase more insurance than may be necessary, leading to inefficiency and excessive cost in the use of health services. With extensive insurance coverage, there is little reason for the employee or the health care provider to be cost-conscious about the type or quantity of health care provided.

The exclusion of employer-provided health contributions is used as a means of "encouraging" employers to offer health plans which are consistent with the pro-competition approach.

- **Increase or eliminate the medical expense tax deduction.** The medical expense tax deduction allows taxpayers to deduct unreimbursed medical expenses exceeding three percent of adjusted gross income. The deduction is a tax subsidy designed to cushion the impact of medical costs not covered by health insurance.

Raising the deduction level would reduce the revenue losses from the provision and provide the tax subsidy only to those taxpayers with very large medical outlays which are unreimbursed by insurance. Raising or eliminating the deduction could introduce an element of cost-consciousness in those taxpayers who can avail themselves of this tax provision.

- **Convert the medical expense tax deduction to a fixed tax credit.** Another element sometimes included in considerations about changing incentives under the tax laws which affect health benefits would change the medical expense deduction to a tax credit. Since the tax subsidy would be fixed and would not vary with the price of the health insurance option chosen, it should encourage employees to purchase less expensive health plans.

A number of questions, however, are being raised in connection with the elements of pro-competition proposals. Adverse selection is a problem in any insurance scheme, though it may be exacerbated if individuals are not only permitted to choose among plans but are encouraged to do so by means of incentives.

If employees are offered a choice between a low-cost option, which might contain more patient cost-sharing or fewer benefits, and a more costly, more comprehensive plan with little or no patient cost-sharing, those employees who expected few medical expenses in the near future could be expected to pick the low-cost plan. Those employees who expected substantial medical expenses might be expected to join or, if given the opportunity to change their enrollment, might switch to the more comprehensive plan until their medical needs were taken care of. If all the high medical risks shifted to the more comprehensive plans, the costs of the comprehensive plans would soar, and the benefits of spreading risk among all members of a group with varying levels of health care needs would diminish.

Another concern is the necessity that buyers of health care be reasonably well-informed about the alternatives they are considering in order to make intelligent choices for themselves. Health care and health insurance are very complex fields, very difficult for the average person to understand fully.

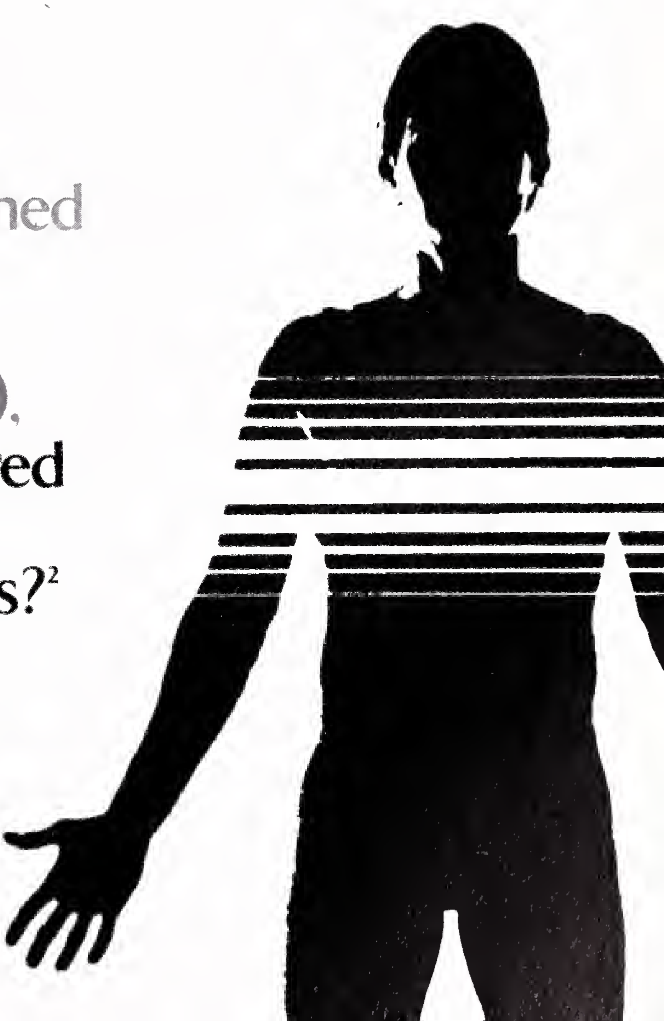
What must be done to make it easier for the average health care consumer to understand his purchase of health care services or health insurance? What would be the cost to the system of any changes or education process that might be necessary? Would there be the incentive to insure inadequately in order to qualify for a cash rebate?

Other questions center on the actual cost savings under pro-competition approaches. Would consumers pay a greater portion of their health bills, in some instances increasing bad debts, and forcing an already over burdened provider audience to shoulder more of such costs?

The major pro-competition proposals introduced in the 97th Congress include:

S. 139(Hatch)
H.R. 850 (Gephardt)
S. 433 (Durenberger, Boren, Heinz)

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), which Step-2 regimen was preferred and was deemed effective without significant adverse effects?[2]



We still need health care regulation, but it must be organized, effective

By Bailus Walker, PhD, MPH
Lansing

Regulation is a vital tool to handling the problems of the modern industrial economy. For years, however, neglect at the top of the government allowed regulation to become a blunt instrument. Some rules imposed needless cost while others failed to prevent health and safety risk. The regulatory assembly line was threaded with conflicts of interest; value judgments were confused with economic and scientific factors and an unintegrated hodgepodge of disconnected decisions.

Unfortunately, managers of public health programs cannot always quantify the impact of their activities. We cannot always engage in the numbers games that so many of our colleagues like to play. It is difficult to clearly identify how many cases of disease did not occur because of our services, or how many deaths were prevented.

Currently, the economy is a matter of serious concern, and it is a very real problem. It is apparent that government regulation has been singled out by critics in both public and private sectors as a major contributor to current economic "crises." More importantly, a chief target of many sound-economy proponents seems to be safety, health and environmental areas.

Consumers want regulations

But most consumers want stricter government regulations in these areas, according to several national and local polls. To them, regulatory reform does not mean swinging an axe through federal or state rule books. It means that they want a greater degree of control over their own lives and to get from government what they pay for: services rendered quickly and without waste.

While government may withdraw from most kinds of economic regulations by the end of the decade, government intervention on health and safety issues is likely to continue and expand. An example is the control of carcinogens in food, water, workplaces and consumer products. Incidents like the kepone release into the James River, Va.; or Berlin and Farro sites in Michigan, or Love Canal in New York are likely to recur. In response to the latter, Congress has enacted legislation, the so called "superfund" to require industry to pay part of the cost of cleaning up hazardous waste disposal. Together with the Toxic Substance Control Act of 1976 and toxic substance control laws enacted by the legislature, these will represent major new initiatives during the next 10 years.

In Michigan the Governor has established a regulatory task force which has among its charges the responsibility for systematic analyses of regulatory issues and processes, to move the state toward the use of less intrusive and burdensome regulations, and to implement more efficient regulatory techniques.

Organization is always the key to more productive systems, whether they involve energy locked up in the ground or energy locked up in federal or state governments. It involves sorting out what we have so we do not waste limited scientific and technical resources by re-inventing the wheel, coming up with "brilliant" solutions to problems solved last week somewhere else in the private or public sector, failing to use what is already available, or worse — coming up with four different solutions to the same problem.

Organization crucial to health

Excellence in organization is nowhere more crucial than in the area of health services for the prevention of acute and chronic diseases. That is why cooperation and coordination of private and public sector activities are so important.

In our determination to work together in providing health services and medical care I see several critical areas we must explore:

- Working out common approaches to the assessment of health risks and benefits.
- Agreeing on methods of obtaining, storing, and exchanging health information.
- Establishing common health

Doctor Walker is Director, Michigan Department of Public Health. This is an excerpt from a speech to the National Health Forum, Jan. 13, Washington, D.C.

research and development policies.

- Establishing public communication and educational programs and information services for providers and consumers of health services.
- Stimulate the flow of epidemiological data.

Most of the knowledge needed to make this effort work resides in health agencies and organizations in the private and public sectors.

But as Philip Handler, chairman of the National Academy of Sciences (who died recently) wrote, "... the manner in which we grope for ways to cope with such matters is extraordinarily debilitating. A major impediment to the formulation of the decision so badly needed is the difficulty we have in agreeing to the interpretation and the reliability of pertinent facts. There is no dearth of relevant reports. But their lack of force derives from public uncertainty as to whether their recommendations arise from dispassionate judgment or are tainted by bias or by conflict of interest in one of its guises."

Throughout the 1980's the debate over regulatory reform also will direct more attention to the relative roles of federal and state governments in health regulation — a matter which has been inadequately considered in the past. Specific issues such as medical technology, health manpower, nursing home care, health care cost, the siting of new hazardous waste disposal sites and the regulation of acid rain will raise questions sharply.

In all of these health issues we will face the generic issues of selecting tools for achieving appropriate goals, finding the most effective level of government and developing ways to approach problems involving substantial uncertainty.

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?[3]

Board of Medicine disciplinary actions

Dec. 16 to Jan. 13

- **John C. Watts, MD**

6800 Schaefer Road
Dearborn, 48126

Date, action taken
January 13, 1982
Summarily Suspended effective 1-13-82

Violation
S.16221(b) (i) — Incompetence.
S.16221(c) (iv) — Obtaining, possessing, or attempting to obtain or possess a controlled substance without lawful authority; or selling, prescribing, giving away or administering drugs for other than lawful diagnostic or therapeutic purposes.
S.16221(g) — A violation, or aiding or abetting in a violation, of this article or of rules promulgated under this article.
S.16221 (a) — A violation of general duty.

- **George D. Stilwill, MD**

2909 E. Grand River Avenue
Lansing, 48912

Date, action taken
January 13, 1982
Reprimand

Violation
S.11(1) (2) (i) — Failure to conform to minimal standards of acceptable and prevailing medical practice.

- **Leo J. Hirsch, MD**

5554 Putnam
West Bloomfield, 48033

Date, action taken
December 16, 1981
Limited License effective 12-16-81

Violation
S.16221(a) — A violation of general duty.
S.16221(b) (iii) — Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

- **John R. Gilmore, MD**

4830 Lakeshore Road
Port Huron, 48060

Date, action taken
December 16, 1981
Limited License effective 12-16-81

Violation
S.11(2) (i) — Departed from or failed to conform to minimal standards of acceptable and prevailing medical practice.

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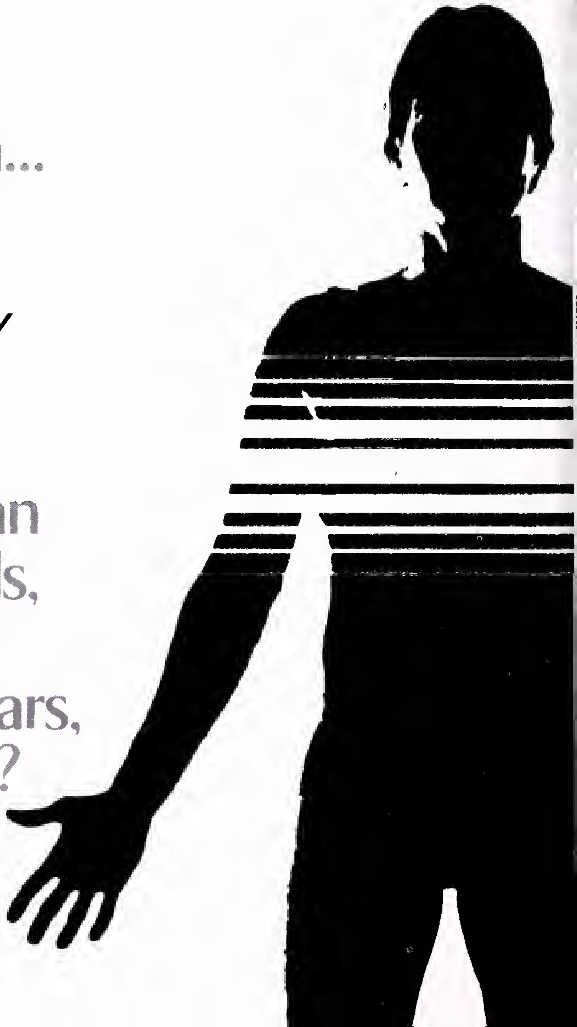
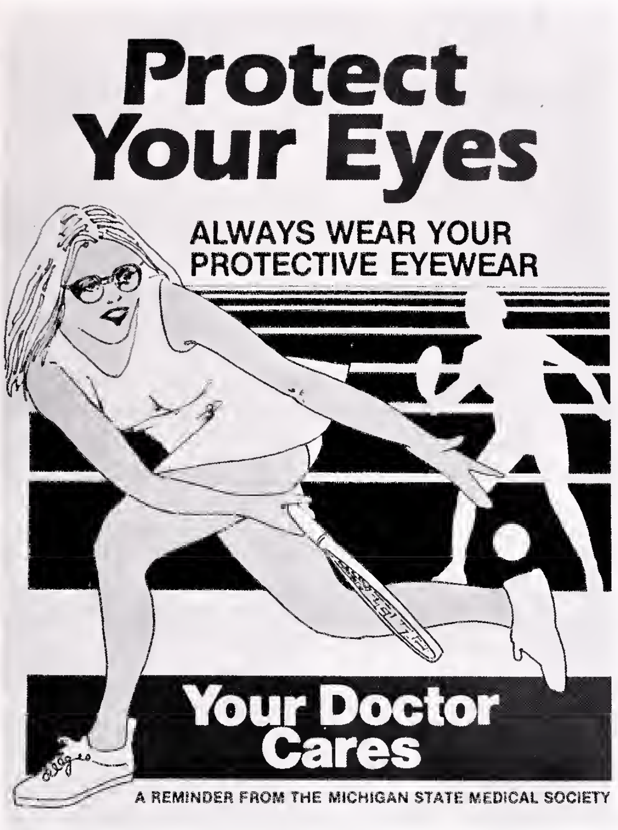
And don't the results of more than $100 million worth of clinical trials, involving thousands of patients who were followed for several years, merit your serious consideration?




Protect Your Eyes
ALWAYS WEAR YOUR PROTECTIVE EYEWEAR
Your Doctor Cares
A REMINDER FROM THE MICHIGAN STATE MEDICAL SOCIETY

MSMS distributes thousands of posters for better eyecare

The eyes have it! The hottest MSMS public service item at the moment is the eye safety poster produced by MSMS in response to a House of Delegates' resolution in 1981. Nearly the entire supply of the 1,500 posters printed initially has been exhausted by the demand for the popular item. Initially, the poster was sent to all Michigan racquetball and handball facilities as well as to YMCAs and country clubs. All Michigan newspapers were sent a copy of the poster with a news release announcing the public effort to encourage court sports participants to wear protective eyewear. MSMS has received upwards of 200 individual requests from sports facilities, ophthalmologists and private citizens asking for one or more copies of the red and brown poster printed on a beige paper. Requests have come from as far away as Texas and New York. Even industrial concerns have asked for copies to post in the workplace as a reminder to employees to protect their eyes. An additional supply of the posters has been printed and any physician desiring a copy for office or personal use may request same by calling or writing MSMS.

And there's more proof on the way!

1982 will see the completion of the Multiple Risk Factor Intervention Trial (MRFIT)—a six-year, 12,000-patient study assessing the factors that increase risk of cardiovascular disease. For the management of hypertension, the preferred Step-2 regimen in this study is reserpine-thiazide.

In 1978, in a preliminary report presented to the Epidemiology Section of the American Heart Association (Dallas, Nov 1978), after 12 months of the trial, fewer patients (5.3%) treated with reserpine suffered depression than even the untreated control group (7.7%)!

Please see references and brief summary of prescribing information on last pages of this advertisement.

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Place this coupon in an envelope and send it to:

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Division of Bristol-Myers Company
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Syracuse, New York 13219

Please provide me with:

☐ Clinical samples of Salutensin® (hydroflumethiazide 50mg/reserpine 0.125mg) and Salutensin-Demi™ (hydroflumethiazide 25mg/reserpine 0.125mg)

☐ Journal article reprints of the clinical studies mentioned in this ad

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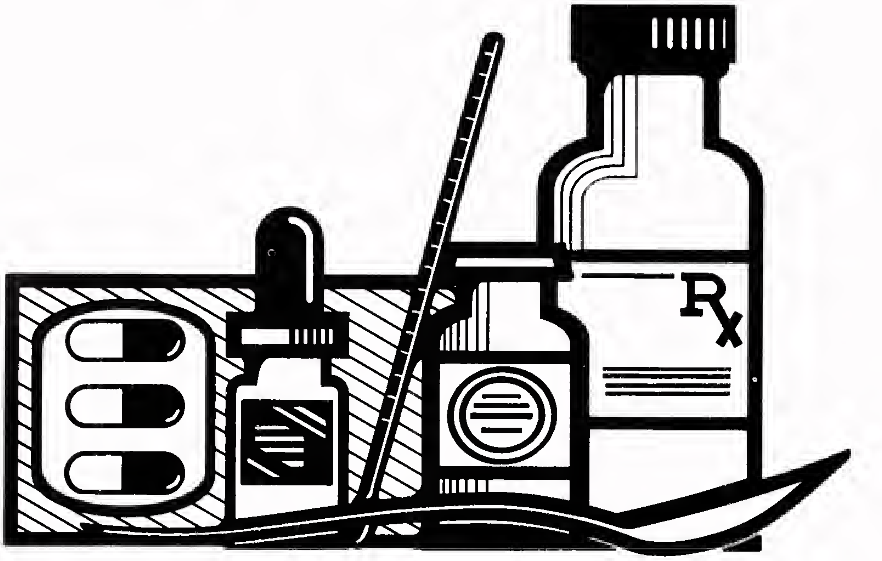
SM-2348 11/81

Macomb County physicians initiate ingenious drug abuse prevention plan



Macomb County medical doctors, osteopathic physicans and surgeons, pharmacists, dentists and podiatrists consider their own drug abuse control more palatable than the dose Uncle might prescribe.

So they have banded together in a unique effort to curb heedless or even illegal prescribing, and overuse by patients in their county.

Their Drug Abuse Prevention Program went into effect Oct. 1. "Our goal with medication, as with the other tools we use, is to heal," they stated then. "Therefore, we are particularly concerned, and committed, to making sure that the drugs we use are not used in ways that bring harm to our patients."

They adopted the following policies:

1. A 24-hour delay will be required to fill all Schedule II prescriptions. The only exceptions will be in cases of acute need and unusual hardship. (See below.)
2. During that 24-hour wait, the pharmacist will call back to the prescribing doctor or similarly licensed designee to verify the Schedule II prescription. The confirmation call will only be made to doctors in their

Salutensin® **Salutensin-Demi™**

(Hydroflumethiazide, Reserpine Antihypertensive Formulation)

Brief Summary of Prescribing Information (12) 10/27/78
For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

offices, where the prescriber has access to the patients' charts.

3. In situations where the Schedule II drug has been prescribed for an acute and immediate need, the "Rule of 12" should be followed: A maximum of 12 doses of the drug may be dispensed immediately. If more than 12 doses are needed, the remainder of the prescription may be dispensed 24 hours later, after the pharmacist verifies the prescription with the prescribing doctor. The balance of the prescription must be picked up within 72 hours.

4. There may be a few cases in which it would be an unusual hardship for the patient to have to return 24 hours later for the prescription. In those cases, pharmacists should use their professional judgment in balancing abuse potential against that hardship. The pharmacist may fill the prescription, after attempting to verify it with the prescribing doctor.

5. If the prescribing doctor, or the doctor's similarly licensed designee, cannot be reached within 24 hours to check on a Schedule II prescription, the pharmacist may fill the prescription and verify it as soon as the doctor becomes available. (A log should be kept of all unverified Schedule II prescriptions over 12 doses).

6. Amphetamines, including methamphetamine, have no valid role for use in appetite control. Because their abuse potential far outweighs any benefit in that use, we urge all doctors to discontinue the use of those drugs for weight control. The only rational uses for Amphetamines are Narcolepsy and the hyperactive child.

Before the new policies took effect, the involved organizations notified all individuals licensed to prescribe or dispense prescription drugs in Macomb County and their patients.

Macomb County Medical Society president participated in a joint committee on drug abuse prevention. which included representatives from all of the participating organizations in Macomb County.

The committee planned to explore additional cooperation to discourage drug abuse and illegitimate prescribing practices and to encourage prevention measures through our organizations. It will report on its six months' experience in April.

ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine

Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

1 tablet b.i.d.

SUPPLIED

Bottles of 100 and 1000 scored 50 mg. tablets.

References:
1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

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A mobile telephone that puts your hands where they belong. Back on the wheel.

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MEDICAL NEWSFRONTS

Four cases of Reye's Syndrome (RS) were reported in Michigan from Dec. 17 to Jan. 6. RS was preceded by respiratory illness in two of these children and chickenpox in a third. The fourth child, a four-month-old infant who exhibited symptoms of both gastroenteritis and respiratory infection prior to onset of symptoms of RS died shortly after admission to the hospital. From Oct. 1 to Jan. 21, 13 cases of RS were reported; of these, there have been two deaths.

As mentioned in an earlier update, The Michigan Department of Public Health is planning to carry out HLA typing on RS cases in collaboration with Michigan State University. The plans for this testing are finished and the department now is collecting specimens for analysis. In addition to the HLA typing, MDPH also is planning to have lymphocyte cell function evaluated on these same specimens.

In the Great Lakes region, the following states have reported RS cases in the period October 1, 1981 to January 4, 1982:

Illinois (0) Minnesota (1) Ontario (0)
Indiana (2) Ohio (8) Wisconsin (0)

A major grant of $4 million from the W.K. Kellogg Foundation of Battle Creek has brought The University of Michigan well over the half way mark toward construction of a $12 million national eye care center.

To be known as the W.K. Kellogg Eye Center, the educational, medical and surgical facility will provide more sophisticated treatment for glaucoma, cataracts, children's eye diseases, diseases of the retina and cornea, neurological diseases related to eye problems, plastic surgery involving the eye, and more effective services for individuals with visual disabilities. It will conduct a major program to identify risk factors which indicate a susceptibility to preventable eye disease and will give special emphasis to problems of the elderly and the diabetic.

The Center will work closely with all disciplines in the education of people for the medical profession and will conduct "mini-residencies" for practitioners as well as regular continuing education for physicians. It will also undertake research as an integral function.

The W.K. Kellogg Eye Center will contain complete outpatient clinical services, three fully equipped operating rooms, a recovery room, 32 inpatient beds, and facilities for education and research. All teaching, research and clinical activities of the U-M department of ophthalmology will be consolidated at the Center after having operated out of seven separate campus buildings.

As many as 50,000 outpatients and inpatients can be served each year in the new facility, an increase in capacity of 20,000 persons. Michigan Eye Bank offices and research laboratories also will be housed in the Center.

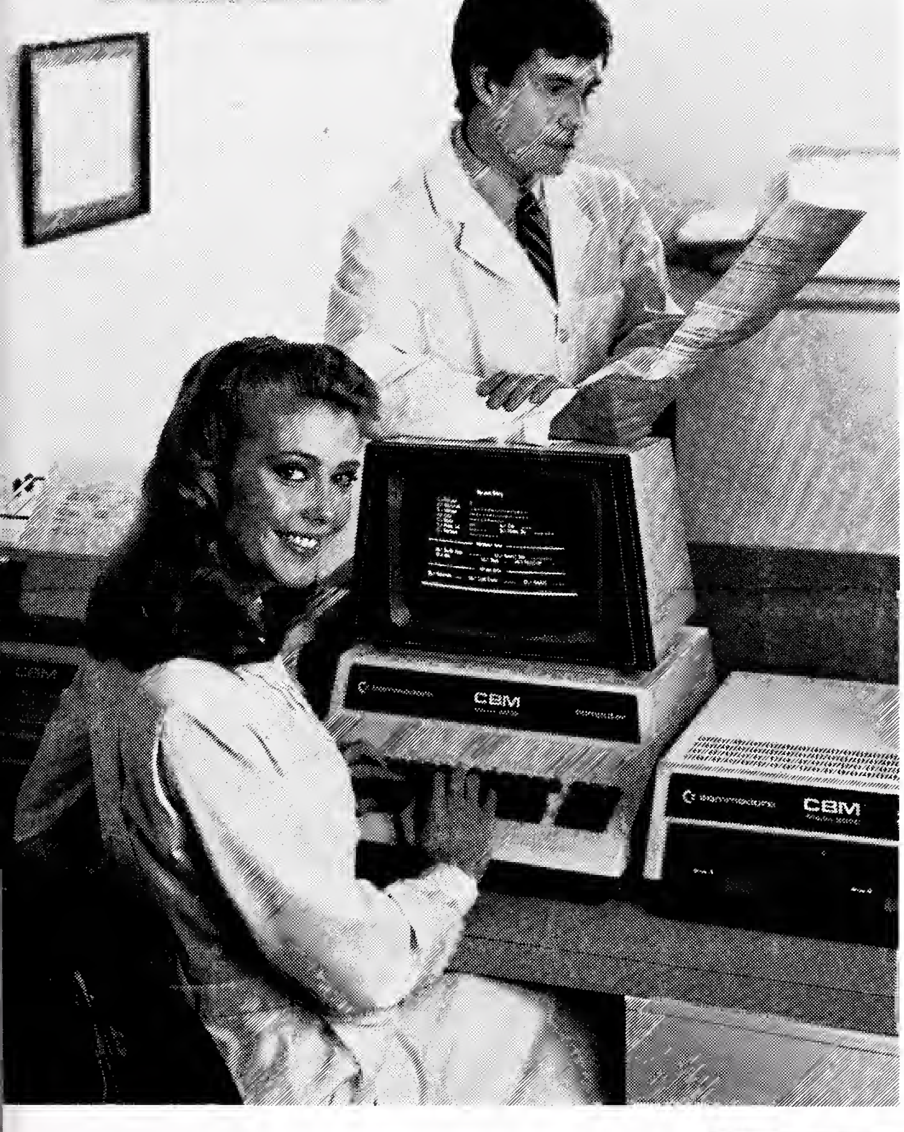
Plastic, air-cushioned bubble strips — similar to those used for packing breakable items for transport — are being used experimentally by Henry Ford Hospital's Department of Neurological Surgery to help reduce tissue damage during brain surgery. The bubble strip pads are being attached to retractors to cushion sensitive brain tissue and help reduce the possibility of damage due to displacement and movement during surgery.

The experimental use of the material was reported at a winter meeting of the American College of Surgeons by Dr. Manuel Dujovny of HFH and colleagues from the University of Chicago and the Veterans Administration Medical Center in Pittsburgh. A group of control subjects (animal) all sustained lesions on the cerebral cortex directly below the site of uncushioned surgical retractors, while subjects on which the bubble strips were used showed no tissue damage or impairment following surgery.

Continued on page 158

"MEDICAL ACCOUNTING PLUS WORD PROCESSING FOR UNDER $6,500. FROM COMMODORE."

—WILLIAM SHATNER



The symptoms are common. Missing receipts. Overdue invoices. Neglected insurance forms. And, worst of all, a lot of precious time spent on paperwork that could otherwise be devoted to patient care.

The cure: A Commodore desktop computer. Including disk drive, letter quality printer, and complete medical accounting and word processing systems. For a modest investment, you get all the features of a sophisticated and versatile business computer that can do virtually all your paperwork in a fraction of the time it takes you now.

Commodore's Medical Accounting System (MAS)[1], for example, can provide you with a fast, flexible accounting and bookkeeping system that's as easy to use as it is cost effective. Automating your receivables, invoicing, aging of payables, and revenue analyses. MAS can also generate end-of-the-month "Superbills" as well as standard insurance and Medicare forms. And it gives you a thorough overview of your office activities through a series of reports ranging from diagnostics to referrals.

And with our word processing programs, your Commodore computer is versatile enough to be used whenever you'd normally use a typewriter. For memos. Reports. Correspondence. Proposals. In seconds, you can delete, insert, rearrange paragraphs, even revise as many times as necessary. With no time wasted typing multiple drafts.

If all that time saved on paperwork is used to take on additional patients, just think how quickly your Commodore computer will pay for itself, many times over.

Your Commodore computer can be expanded to meet the needs of a growing office. And Commodore dealers throughout the country offer prompt local service. Visit your Commodore dealer for a hands-on demonstration of the Commodore computer that does so much, so easily, at such a low cost.

---

[1] Medical Accounting System was created by Cimarron Corp.

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NEWSFRONTS/Continued

Kidney stones are a major health problem which affects an estimated 1.1 per cent of the population nationwide. To help diagnose and plan treatment for the approximately one in every 1,000 adults who suffers the dreadful pain of kidney stones, a team of urologists, nephrologists and mineral metabolism specialists from Henry Ford Hospital conducts a monthly Kidney Stone Clinic at the West Grand Boulevard HFH facility.

In HFH's Kidney Stone Clinic, the patient undergoes a complete evaluation to find out the possible cause of the stone and plans treatment to prevent new stones from forming.

According to D.S. Rao, MD, a specialist in calcium disorders, "Anyone can have kidney stones at any age, although the rate is three times higher in men than in women. Most patients have a metabolic disorder so that their bodies don't handle minerals (such as calcium) well. About five per cent may have an underlying parathyroid gland disorder which results in a high blood and urine calcium level; this can best be treated by surgical removal of the abnormal parathyroid glands.

For further information about the HFH Kidney Stone Clinic, please call (313) 876-2702.

Although researchers generally agree that cancer arises from a single abnormal cell, by the time the emerging tumor reaches detectable size it may contain different types of malignant cells.

Research on the diverse nature of cancer cells, being done at a number of centers, suggests that it is the differences among the cells in a cancer that make it more susceptible to combination therapy involving radiation and drugs or combinations of drugs rather than the single therapy approach.

But the differences among the cells — known as heterogeneity — also may account for why similar appearing cancers don't always respond the same to therapy.

According to a report of a recent symposium in the Medical News section of the *Journal of the American Medical Association*, researchers have found single cancers comprised of cells differing in their secretory products, in their sensitivity to hormones, and in their genetic characteristics. The symposium, sponsored by Bristol-Meyers, was held at The John Hopkins Oncology Center in Baltimore.

University of Michigan Hospitals Jan. 7 unveiled a new emergency services unit that also will serve as a regional trauma facility for Southeastern Michigan.

The new Emergency Services unit, which occupies a renovated wing of the U-M Hospitals Ambulatory Care Building, "has been redesigned, rebuilt and re-equipped to handle, effectively and efficiently, every medical or surgical need from a painful sore throat to a major highway disaster," according to James R. Mackenzie, MD, chief of the U-M Emergency Services.

The unit has been carefully designed to maintain closeness between patients, nurses and U-M faculty doctors who provide and supervise care 24 hours a day.

Most walls separating the formerly isolated treatment rooms have been removed, hospital officials said. The rooms have been replaced by specially equipped and designed trauma bays grouped around a physician-nurse staff center so that patients are under constant observation.

Hospital officials say the single technological improvement that will most enhance the efficiency of care is the $8,000 "power column" in each of the three trauma bays. These columns consolidate most emergency treatment equipment for restoring vital functions, such as oxygen, other gases, defibrilator, electrocardiogram, suction, infusion pump, heart monitor, plus space for other surgical supplies and equipment.

First Class First Aid

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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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J-9043-4 July 1981

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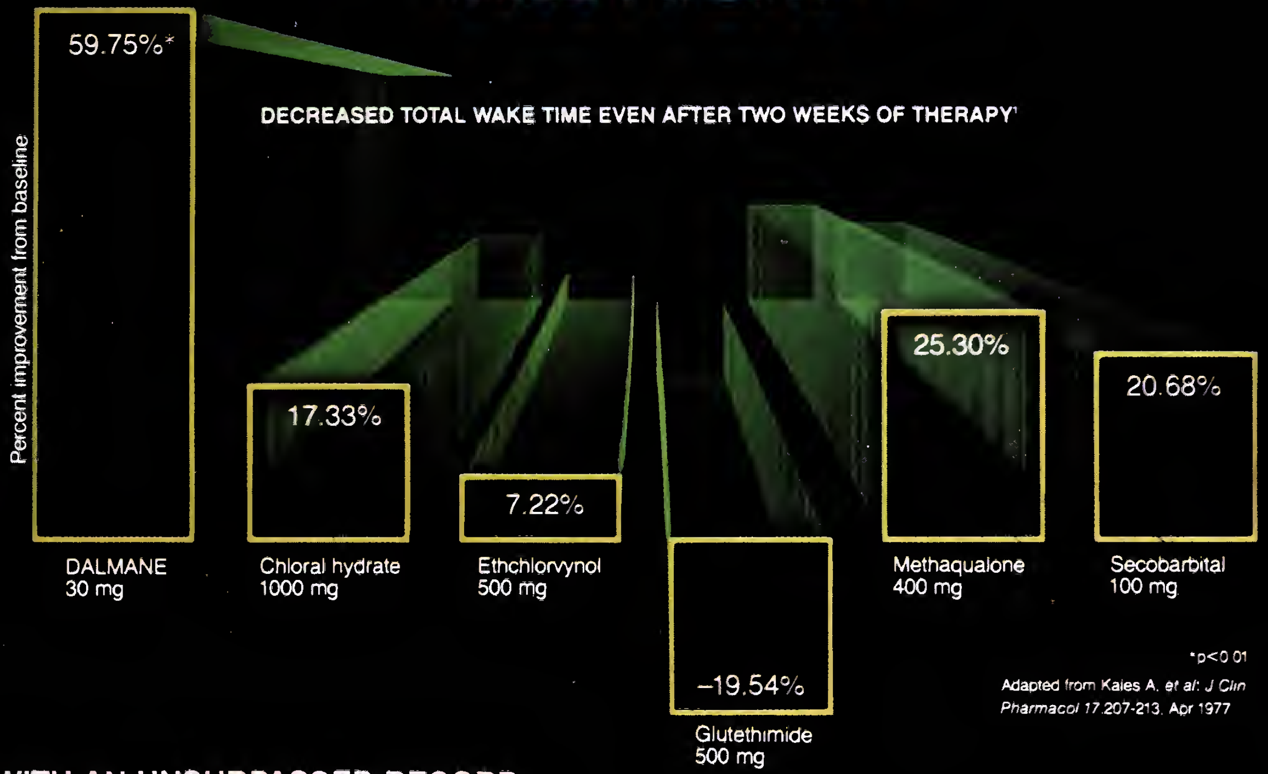

*$p<0.01$

Adapted from Kales A, *et al: J Clin Pharmacol* 17:207-213, Apr 1977

WITH AN UNSURPASSED RECORD OF EFFICACY AND SAFETY

The efficacy of Dalmane (flurazepam HCl/Roche) has been documented in 185 studies involving 9141 patients suffering from one or more of the three major forms of insomnia–difficulty falling asleep, staying asleep and sleeping long enough.[2]

Relative safety was demonstrated in a large study of 2542 hospitalized medical patients. Only 3.1% of these patients reported adverse reactions–predominantly unwanted residual drowsiness. None of the reactions were considered serious by attending physicians.[3]

FOR SLEEP WITHIN 17 MINUTES[2] AND NO WORSENING OF SLEEP ON DISCONTINUATION

Rapid sleep induction, within 17 minutes on average, sets the stage for insomnia relief. And, after discontinuation of Dalmane for periods ranging up to 14 nights, no worsening of sleep compared with baseline was observed.[4]

Should insomnia recur, the patient may require guidance in setting up a regular sleep program to help provide the optimum environment for the onset of natural sleep. If hypnotic therapy is required, it should be given for the shortest time at the lowest effective dose to achieve the desired goal.

Consider other medications the patient may be taking (including alcoholic beverages) and be aware of possible drug interactions. Please note that patients should be treated for underlying physical or psychological factors before therapy with a sleep medication is undertaken.

DALMANE® Ⓒ IV
flurazepam HCl/Roche

THE STANDARD OF HYPNOTIC EFFICACY FROM THE LEADER IN SLEEP RESEARCH

ROCHE®

Please see reverse side for a summary of product information.

EFFECTIVE
ALL NIGHT

SLEEP-SPECIFIC
DALMANE® Ⓒ
flurazepam HCl/Roche

One 15-mg capsule *h.s.*–recommended initial dosage for elderly or debilitated patients.
One 30-mg capsule *h.s.*–usual adult dosage
(15 mg may suffice in some patients).

THE STANDARD FOR HYPNOTIC EFFICACY WITH IMPORTANT ADDED BENEFITS

- Well tolerated[2]
- No chemical interference with many commonly ordered laboratory tests, including triglycerides, uric acid, glucose, SGOT, alkaline phosphatase and total protein[5,6] (See adverse reactions section of complete product information.)
- Compatible with chronic warfarin therapy; no unacceptable fluctuation in prothrombin time reported[7,8]

UNLIKE NONSPECIFIC MEDICATIONS USED FOR SLEEP

Tricyclic antidepressants

–which are *not* sleep specific,[9] yet are sometimes used in nondepressed patients for sleep

–which can cause transient insomnia in the elderly[10]

–which can require careful monitoring in cardiovascular patients[10]

–which have strong anticholinergic effects[10]

Antihistamines

–which are *not* reliable sleep-inducing agents[11]

–which may produce stimulation instead[11]

–which have anticholinergic effects[11]

Major tranquilizers

–whose side effects may be troublesome for nonpsychotic patients[12]

–where tolerance for sedation appears rapidly[12]

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.[4]

References: 1. Kales A. *et al*: *J Clin Pharmacol 17*:207-213, Apr 1977 **2.** Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ 3. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977 **4.** Kales A, *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975 **5.** Moore JD, Weissman L: *J Clin Pharmacol 16*:241-244, May-Jun 1976 6. Spiegel HE: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ 7. Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, pp. 641-646 **8.** Warfarin Study: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **9.** Baldessarini RJ: Drugs and the treatment of psychiatric disorders, chap. 19, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp. 391-447 **10.** Cole JO, Davis JM: Antidepressant drugs, chap. 31.2, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1941-1956 **11.** Douglas WW: Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap. 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp. 609-646 **12.** Davis JM, Cole JO: Antipsychotic drugs, chap 31.1, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.
Adults: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®

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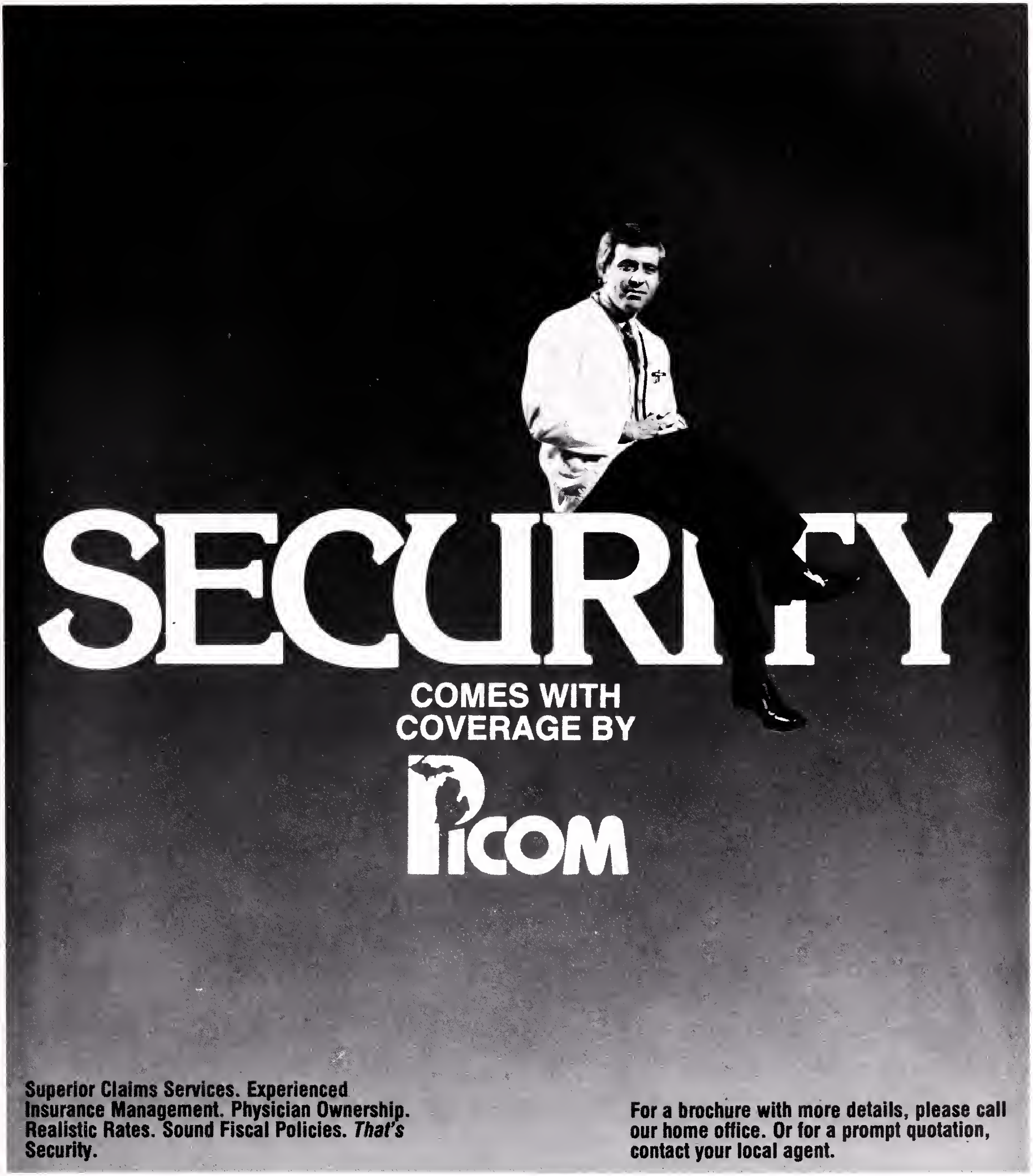

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Here's a malpractice case that went in the doctor's favor

The following item was prepared for *Michigan Medicine* by MSMS Legal Counsel A. Stewart Kerr, for MSMS member's interest.

One night in 1975, Ronald Matts suffered a serious automobile accident. He was taken to the emergency room of a Michigan community hospital. Doctor H. was called to the emergency room after being told by the physician on duty that a young man had been brought in with internal abdominal bleeding. The emergency room at this hospital was manned on a temporary basis by staff physicians. Doctor H. was on staff but was not on call that night. He had no direct responsibility to respond to a request for assistance.

Doctor H. determined that Mr. Matts needed surgery, received the family's permission, and admitted the man to the hospital. After several hours of surgery, the patient began to improve. But the next day his condition deteriorated.

He was transferred to another hospital where further surgery was performed, this surgery disclosing that there were unrepaired tears to the mesentery tissues and several unrepaired holes in his small intestines. The subsequent surgery (by others) and post-operative care were unsuccessful. Mr. Matts died.

Doctor H. was sued for negligence.

Doctor H., a staff physician, was not on call, there was no doctor/patient relationship, and a "life threatening emergency" did indeed exist when Doctor H. came into the emergency room.

Therefore, he was not liable for malpractice absent a showing that he acted in a grossly negligent manner or intended to cause the death or acted in utter disregard of the consequences of his conduct. As those things could not be shown, the doctor acquired (partial) immunity for his acts under the Michigan statute (MCLA §691.1502). The court was therefore not called upon to decide whether there had been *any* negligence.

But we here note that even if there had been ordinary negligence, the court indicated that the doctor's Good Samaritan activity was immunized in the absence of the gross negligence or reckless disregard above noted.

This directed verdict, sustained in the Court of Appeals, was the correct result. It is worth remembering that what would obviously be true in a Good Samaritan, "roadside" setting loses nothing by being in a hospital setting and by the fact that the emergency physician "admitted" the man instead of merely attending him in some non-medical emergency setting.

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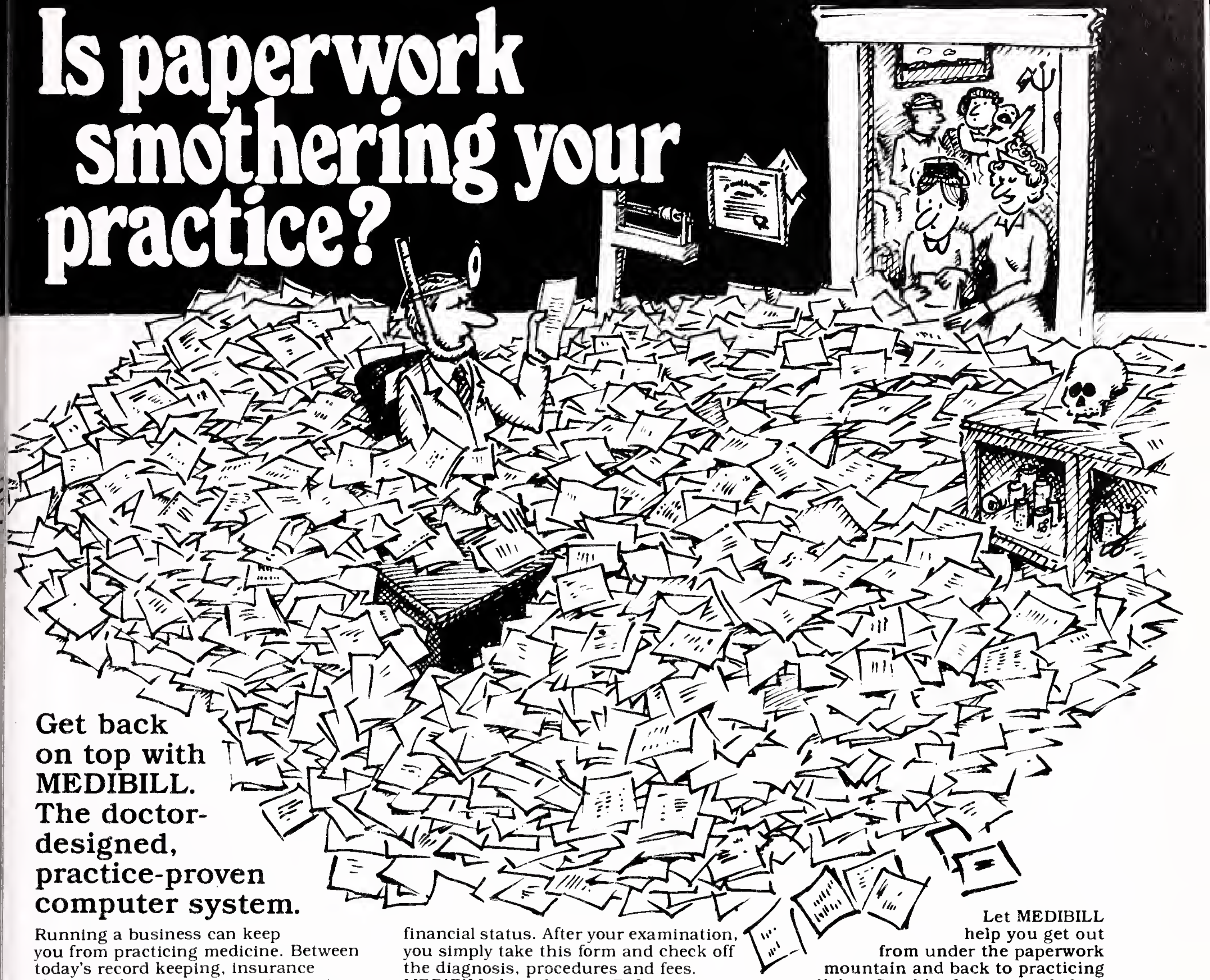

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MSMS brochure gains wide acceptance

Lansing Mayor Terry McKane receives the first copy of the MSMS brochure, "If Illness Strikes While You are Away," distributed at the city's Convention and Visitor's Bureau. The information will be made available to 25,000 bowlers who will attend the State Women's Annual Bowling Tournament February-June, and later this year to 5,000 players on 300 softball teams competing in statewide competition. In addition, the brochure is being distributed with cooperation of the Michigan Department of Transportation at 10 of the state's most frequently-used rest stops, and has been presented by some manufacturing firms to their employees. MSMS members all received a copy in a recent mailing and may obtain more copies for their patients by contacting Mert Scholten at MSMS headquarters.

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	OTHER			
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NEWS

By Sheri W. Greenhoe
East Lansing

Bertram Pitt, MD, professor of internal medicine at the U-M Medical School, is new chairman of the American Heart Association's Council on Circulation. . . . The Sebewaing Chamber of Commerce honored **Joseph Sidagis, MD** and **John Zuzga, DO,** at a recent dinner recognizing their many years of service to the community. Officials presented the two men with plaques commemorating their work on behalf of area residents. . . . **Charles A. Thompson, MD,** is serving his eleventh-consecutive one year term as chief of staff at Hurley Medical Center, Flint. . . . It was reported in the January *Michigan Medicine* News column that William A. LeMire, III, MD, was presented with a golden timepiece from Abbott Laboratories for his 50 years of service and dedication to medicine. The news item should have cited **William A. LeMire, II, MD,** general practitioner, as the recipient of the award. . . . **Delmar Mahrt, MD,** Bloomfield Township, is a new trustee of the Comprehensive Health Planning Council of Southeastern Michigan. Doctor Mahrt represents the Oakland County Medical Society. . . . New president-elect of the Eye Bank Association of America is **Busharat Ahmad, MD,** Marquette. He will take office as president in July, 1983. . . . The Michigan Psychiatric Society honored **Harry E. August, MD** at the Renaissance Center recently for his outstanding contributions to medicine, psychiatry, and psychoanalysis. . . . **Leonard Bender, MD,** chairman of Physical Medicine and Rehabilitation at Wayne State University School of Medicine, has been named chairman of the Professional Advisory Council of the National Easter Seals organization. . . . **Tommy N. Evans, MD,** chairman of obstetrics and gynecology at the WSU School of Medicine, represented the US during the meeting of the executive board of the International Federation of Gynecology and Obstetrics in Melbourne, Australia in October. . . . The American College of Chest Physicians honored **Agustin Arbulu, MD,** WSU clinical professor of surgery, with one of five Best Research Paper awards recently. . . . **Marshal J. Blondy, MD,** clinical professor of pediatrics at WSU, is a new director of the American Association of Automotive Medicine. . . . The University of Michigan Medical School has established the Sophie Jones Lectureship on Infectious Diseases in honor of the school's first black woman graduate. **Sophie Bethena Jones, MD,** a native of Chatham, Ontario, Canada, graduated in 1885 and later practiced in Atlanta and in Kansas City, MO. Doctor Jones, who died in 1932, is also believed to have been the first black women doctor in the United States. . . . **Emil Alberding, MD,** Portage, was recently elected to the Michigan Hospice Organization Board of Directors. . . . **Theodore A. Reyman, MD,** Detroit was elected president of the Michigan Society of Pathologists at the society's December meeting. New president-elect is **Sheldon F. Markel, MD,** Ann Arbor. . . . Internationally known pediatrician **Marshall H. Klaus, MD,** has been appointed professor and chairman of the Department of Pediatrics and Human Development at MSU's College of Human Medicine. Doctor Klaus is known for his work with newborns and for research on early child development. He comes to MSU from Case Western Reserve University. . . . The following MSMS members have been appointed to the MSMS Task Force to Develop a Quality Assurance Proposal, charged with studying possible MSMS peer review involvement: **Gerald H. Mandell, MD,** Detroit, chairman; **Charles W. Aldridge, MD,** Grand Rapids; **John B. Bryan, MD,** Royal Oak; **William S. Carpenter, MD,** Detroit; **Henry M. Domzalski, MD,** Detroit; **Daniel J. Fall, MD,** Ann Arbor; **James E. McGillicuddy, MD,** Lansing; **George F. Newman, MD,** Dearborn; **Robert C. Packer, MD,** Muskegon. . . . Invited to serve as MSMS representative on the Access and Oversight Committee, Michigan Health Data Corporation is **V. Dale Barker, MD,** Hart. . . . **Thomas C. Payne, MD,** Lansing, will represent MSMS in the Department of Public Health's Office of Substance Abuse Services public awareness campaign. . . . **Roy T. Bergman, MD,** FACS, Escanaba general surgeon, has been nominated as head physician for the USA Pan American team to the Pan American Games in Caracas, Venezuela to be held Aug. 20 - Sept. 3. In addition, Doctor Bergman will act as team physician for the US Rowing Association Elite Mens Team to the World Championships in Luzern, Switzerland in August, and will be serving on the Medical Committee of the US Olympic Council of Sports Medicine through 1984. . . . Two physicians at Detroit Receiving Hospital's emergency department have been awarded Michiganian of the Year awards. **Ronald Krome, MD,** and **Judith Tintinalli, MD,** emergency section chief and vice-chief respectively, headed up the emergency department with a 99 percent survival rate, giving it a national reputation for excellence. The Detroit News sponsors the awards, and selected Doctors Krome and Tintinalli and eleven others from among 200 nominations.

Ms. Greenhoe is editorial secretary to *Michigan Medicine.*

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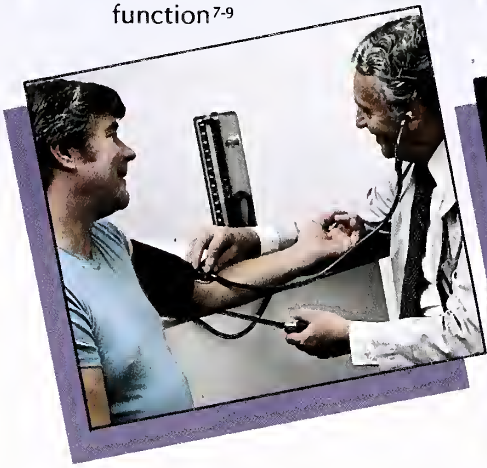

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Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York, Stratton, 1976, pp 221-245. 3. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 4. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 5. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 7. Puschett JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 8. Craswell PW, Ezzat E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 9. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 10. *Drug Topics Red Book 1981*, and manufacturers' suggested prices.

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A-297

MSMS assembled 40 physicians who are component society presidents, committee chairmen and MSMS officers Jan. 20 for a workshop on how Michigan's organized medical system works, and on how better to conduct medicine's business through committee meetings. The crowd, which also included component society and MSMS staff, overflowed the MSMS board room.

MSMS 'Calls in the Team'

Michigan State University Communications Professor Gordon L. Thomas, PhD, provided the group some insights into making Robert's Rules of Order work for a group. He told them the most important job for the leader of a small group is to attain cohesiveness.

MSMS Council Chairman Thomas R. Berglund, MD, described how MSMS works and outlined some goals for MSMS activities. The theme of the day-long seminar was "Calling in the Team."

A coffee break was shared by two attendees, James E. MacVicar, MD, Kalamazoo, Academy of Medicine president, left; and Richard J. McMurray, MD, Flint, member of the AMA delegation from Michigan.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Saturdays, 8:30 am to 11:30 am, Sept.-June. Orthopedic Conference. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Continuing Medical Education. **Contact:** Dr. E. Guise (313) 878-2188. **Approved for:** 3 hours of Category I Credit.

Date: Wednesdays, 7:00 am to 10:00 am, Jan.-Dec. Emergency Medicine Conference Series. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Continuing Medical Education. **Contact:** Dr. James Nowakowski (313) 876-1552. **Approved for:** 3 hours of Category I Credit.

Date: March 24, Diabetes Management: The State of the Art. Location: Henry Ford Hospital Education & Research Building. **Sponsor:** HFH Office of Medical Education. **Contact:** Continuing Medical Education Office, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit 48202, (313) 876-1464. **Approved for:** 6 hours of Category I Credit.

Date: March 24, New Approaches in the Diagnosis and Management of Ischemic Heart Disease. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **Contact:** Wendy L. Frisch, Towsley Center, U-M Medical School, Ann Arbor 48109 (313) 764-2287. **Approved for:** 8.25 hours of Category I Credit.

Date: April 1-2, Third Annual Pulmonary Rehabilitation Symposium. Location: Kalamazoo Center Hilton Inn. **Co-Sponsors:** Borgess Medical Center Pulmonary Unit and Southwestern Michigan Area Health Education Center. **Cost:** $65, one day; $80, both days. **Contact:** Pam Ely, Staff Assistant, Borgess Medical Center, Pulmonary and Special Diagnostic Services, 1521 Gull Road, Kalamazoo, 49001. (616) 383-7229. **Approved for:** 10 hours of Category I Credit.

Date: April 3, Cardiovascular Disease and Anesthesia. Location: Kalamazoo Center Hilton Inn. **Co-Sponsors:** Kalamazoo Anesthesiology, PC, and Southwestern Michigan Area Health Education Center. **Cost:** $60. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, Southwestern Michigan Area Health Education Center, Stryker Ctr., 4th Floor, 1521 Gull Road, Kalamazoo, 49007 (616) 388-7877. **Approved for:** 7 hours of Category I Credit.

Date: April 7, High Risk Obstetrics: The Malformed Fetus. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $85. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, University of Michigan, Ann Arbor 48109 (313) 764-2287. **Approved for:** 6.25 hours of Category I Credit.

Date: April 16-17, Spring Symposium in Radiation Oncology. Location: Towsley Center for Continuing Medical Education, U-M Medical School. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **Contact:** Wendy L. Frisch, Towsley Center for Continuing Education, Box 057, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 12.75 hours of Category I Credit.

Date: April 20-24, Spring Family Practice Review: Clinical Update. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Office of Continuing Medical Education, The University of Michigan Medical School. **Cost:** $395. **Contact:** Wendy L. Frisch, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 35.5 hours of Category I Credit.

Date: April 22-23, Eleventh Annual Critical Care Symposium. Location: Michigan Inn, Southfield. **Sponsor:** Wayne State University, Department of Surgery. **Contact:** Theresa Sokol, (313) 577-5009. **Approved for: 12 hours of Category I Credit.**

Date: April 23-25, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU

Continued on page 178

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MSMS Sports Medicine Conference

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Wayne State University School of Medicine Alumni Association 114th Annual Medical Alumni Reunion Day

Wednesday, May 5, 1982
Michigan Inn
Southfield, Michigan

CLINICAL PROGRAM TOPIC:
New Horizons in Medicine
5 hours CME Credit – Category I

REGISTRATION
8:30 a.m.-9 a.m.

FEES:
$25.00 for WSU Medical Alumni Association members
$50.00 for non-members

MORNING SESSIONS:
9 a.m.-11:30 a.m.
Indepth discussion on invasive treatment for acute coronary disease.
Fareed-Uddin Khaja, M.D., Henry Ford Hospital,
University of Michigan School of Medicine; formerly
with Harvard Medical School
Topic — Use of Streptokinase in acute myocardial infarction
Frederick Levine, M.D. — Sinai Hospital, Wayne State University
School of Medicine
Topic — Surgical intervention in acute myocardial infarction
Waldemar Wajszczuk — Wayne State University School of Medicine
Topic — Angioplasty for acute coronary
Ernest J. Ring, M.D. — University of Pennsylvania School of Medicine
Topic — Catherization and angioplasty
Arthur Klass, M.D. — Sinai Hospital, Wayne State University
School of Medicine
Topic — Laser treatment of gastrointestinal disease

LUNCH:
11:30 a.m.-1:30 p.m.
(Compliments of WSU Alumni Association)
Presentation of student and distinguished alumni awards
Annual business meeting

AFTERNOON SESSIONS:
1:30 p.m.-4:30 p.m.
Henry L. Nadler, M.D., Dean, Wayne State University
School of Medicine
Topic — Predicting disease through genetics
John A. Galloway, M.D., Indiana University School of Medicine,
Lilly Laboratory for Clinical Research
Topic — Biosynthetic human insulin, its production and promise
Samuel Gershon, Wayne State University School of Medicine
Topic — New treatments for Dementia

CATEGORY I/Continued

Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: April 24, The Medical Consequences of Nuclear Weapons and Nuclear War. Location: Music Hall Theatre, Detroit. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** WSU Division of Continuing Medical Education, University Health Center, 9B32, Detroit 48201 (313) 577-1180. **Approved for:** 5 hours of Category I Credit.

Date: April 25-29, Midwest Conference on Alcohol and Drug Abuse. Location: Valley Plaza, Midland. **Sponsor:** Bay Medical Education. **For:** All interested physicians. **Cost:** $225. **Contact:** James R. Tarrant, Director of Medical Education, Bay Medical Education, 615 Ninth St., Bay City 48706, (517) 892-1501. **Approved for:** 19 hours of Category I Credit.

Date: April 26-27, Modern Approaches to Eye Plastic and Orbital Surgery. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $255. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, University of Michigan, Ann Arbor 48109 (313) 764-2287. **Approved for:** 14 hours of Category I Credit.

Date: April 26-30, Advanced Muscle Energy Tutorial (Below Diaphragm). Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: May 5, Wayne State University Medical Alumni Association Reunion and Clinic Day Topic: New Horizons in Medicine. Location: Michigan Inn, Southfield. **Sponsor:** Wayne State University Medical Alumni Association. **For:** Wayne State University Medical Alumni. **Contact:** WSU Medical Alumni Association, 540 E. Canfield, Detroit 48201, Room 1132, (313) 577-1495. **Approved for:** 5 hours of Category I Credit.

Date: May 6, 7, 8, Management of Coronary Artery Disease. Location: Westin Hotel, Detroit. **Sponsors:** Michigan Heart Association and American Heart Association. **Contact:** Eleanor D. Peterson, RN, Program Consultant, Michigan Heart Association, 16310 W. 12 Mile Road, PO Box 160-LV, Lathrup Village, 48076 (313) 557-9500. **Approved for:** 17 hours of Category I Credit.

Date: May 7-8, Nuclear Radiology Workshop with Minisymposia in Cardiopulmonary Nuclear Medicine and Updates in General Nuclear Medicine. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Office of Continuing Medical Education, The University of Michigan Medical School. **Cost:** $195. **Contact:** Wendy L. Frisch, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109 (313) 764-2287. **Approved for:** 15 hours of Category I Credit.

Date: May 12-13, "Perinatology: Transitions, Trends and Tragedies." Location: Kalamazoo. **Sponsor:** Bronson Methodist Hospital. **For (specialty):** all interested physicians. **Contact:** Valerie Lincoln, RN, Perinatal Coordinator, Bronson Medthodist Hospital, 252 E. Lovell, Kala-

Continued on page 180

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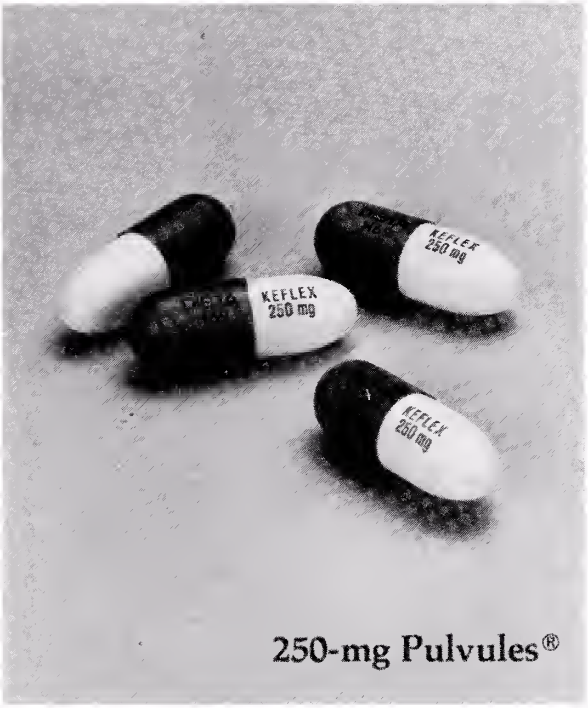

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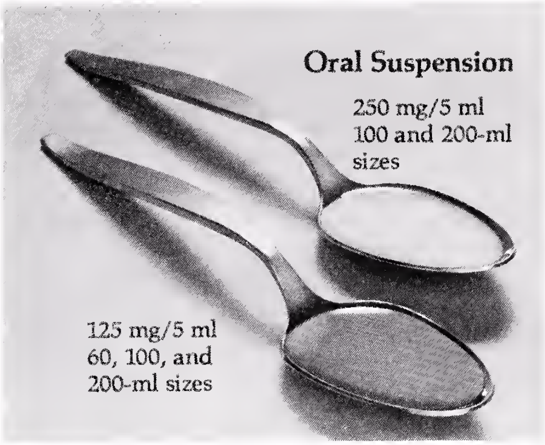

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CATEGORY I/Continued

mazoo 49006. **Approved for:** 5 hours of Category I Credit for each day's attendance.

Date: May 14-16, May Seminar, Michigan Society of Pathologists. Location: Bay Valley Inn, Bay City. **Contact:** Willys Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint (313) 766-0000). **Approved for:** 3 hours of Category I Credit.

Date: May 15-16, "Lymphoma and Leukemia" and "Soft Tissue Tumors & Tumor-like Conditions." Location: Bay Valley Inn, Bay City. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** Willys F. Mueller, Jr., MD, Department of Pathology, Hurley Medical Center, One Hurley Plaza, Flint 48502 (313) 766-0134. Each of the two programs is **Approved for:** 3 hours of Category I Credit.

Date: May 17-21, Advances in Internal Medicine. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Office of Continuing Medical Education, The University of Michigan Medical School. **Cost:** $425. **Contact:** Wendy L. Frisch, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109 (313) 764-2287. **Approved for:** 35 hours of Category I Credit.

Date: June 3 and 4, Prevention of Hereditary Large Bowel Cancer. Location: Westin Hotel, Detroit. **Sponsors:** Comprehensive Cancer Center of Metropolitan Detroit, Michigan Cancer Foundation, American Cancer Society, and National Large Bowel Cancer Project. **Cost:** $150. **Contact:** Elizabeth R. Holben, Michigan Cancer Foundation, 110 E. Warren Avenue, Detroit, 48201 (313) 833-1710. **Approved for:** 10 hours of Category I Credit.

Date: June 9, Medical Update in Family Practice, "The Geriatric Patient". Location: Saint John Hospital, Detroit. **Sponsor:** Continuing Medical Education Committee of Saint John Hospital. **For (specialty):** all interested Family Physicians. **Contact:** Linda Campbell (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 14-18, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine, and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 18-20, 33rd Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University Department of Surgery. **Contact:** B. E. Henig, MD, Keyport Clinic, P.O. Box 605, Grayling 49738 (517) 348-6611. **Approved for:** 12 hours of Category I Credit.

Date: July 22-25, Fourteenth Annual Summer Conference — Update for General Practice Ophthalmologists. Location: Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Cost:** $150. **Contact:** Leslie E. Meissner, MOS Administrative Assistant, (313) 839-3011. **Approved for:** 8 hours of Category I Credit.

Date: July 22-26, Intermediate Course on Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: July 30-Aug. 1, Arrhythmias and Cardiac Ischemia: Diagnosis and Management. Location: Boyne Mountain Resort, Boyne City. **Sponsor:** International Medical Education Corporation. **For:** Physicians, nurses and technicians. **Cost:** Physicians — $245, Nurses and technicians — $130. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, 64 Inverness Drive East, Englewood, CO 80112 (303) 773-1144 or 800-525-8646. **Approved for:** 13 hours of Category I Credit.

Date: Aug. 23-27, Tutorial on Direct Action Thrusting. Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: September 10-12, Fifth Annual Course in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Department of Radiology and Department of Postgraduate Medicine and Health Professions Education, The University of Michigan Medical School. **For:** all interested physicians. **Cost:** $275. **Contact:** David Bruce Youel, MD, Director, Office of Continuing Medical Education, Towsley Center, U-M Medical Center, Ann Arbor 48109 (313) 763-1423. **Approved for:** 16 hours of Category I Credit.

Date: Oct. 14-17, Annual Regional Meeting of the Michigan Chapter, American College of Physicians. Location: Traverse City Hilton. **Sponsor:** American College of Physicians, in association with the Michigan Society of Internal Medicine. **Contact:** Arnold R. Axelrod, MD, Sinai Hospital of Detroit, (313) 493-5780. **Approved for:** 25 hours of Category I Credit.

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Patient education requires MDs to examine own interpersonal allergies

The physician and the entire staff must work closely with the patient for effective programs of patient education and health promotion.

That advice was given by three speakers at the course "Why Educate Patients? Why Not?" during the 1981 MSMS Annual Scientific Meeting at the Dearborn Hyatt Regency.

Patient education must be a team effort of the physician and the entire staff, stressed Shirley Licking, president of the American Association of Medical Assistants, Inc., State of Michigan, herself a medical assistant for a Jackson surgeon.

Together, the doctor and the staff should decide (1) when (2) who and (3) how to educate, she said. She added that an excellent time to start patient education is when the patient makes the first phone call to the doctor or when the patient comes in for the first office visit.

Ms. Licking offered practical advice for the medical assistants in the course. She urged them to be referral agents to other medical and community services, and to learn what materials are available from the voluntary and state agencies offering health information. She expressed a real concern that the medical assistant help the patient understand why they are taking certain medication.

What's on TV?

"I personally feel that medical assistants should keep up to date on what medical TV programs are coming up and what topics they will deal with. Patients often seek advice before programs — and more often after some medical expert or TV drama has focused on some health problem or cure," she added.

Ms. Licking recognized that patients often bring with them to the office the spouse or parents or children or friends as support. "There are great opportunities for the doctor and his/her staff to inform, educate, motivate the 'group' that comes with the patient."

"Remember that every encounter that a patient has with the physician or the MD office is patient education . . . and the patient usually will comply only when he/she understands," declared Ross Egger, MD, family physician from Daleville, Ind. He is a frequent speaker at AMA and American Academy of Family Physicians continuing education courses and conferences on patient education and health promotion.

Doctor Egger defined "patient education as a means of accomplishing (1) increased patient responsibility, and (2) increased patient confidence in his/her ability to diagnose feelings and conditions".

The physicians and medical assistants enrolled in the course seemed very interested in Doctor Egger's suggestions for what a physician can do in a 15-minute visit.

After the greeting, he said, the physician should elicit the problem(s), do an examination, and to try to cover five aspects of patient education.

Doctor Egger urged the doctor to:

- Explain his findings.
- Talk about differential diagnosis.
- Explain possible therapy and side effects.
- Talk about possible outcomes.
- Explain when and why to contact the doctor again. Time should be provided then, he said, for doctor/patient interaction.

The conclusion of a visit, he said, should include asking the patient if he/she has any other questions and making sure there are no unanswered questions and the doctor should try to do all of these things without appearing to be rushed.

To teach patients effectively, physicians must examine their own "interpersonal allergies" and learn to treat their own problems, declared Norman Kagan, PhD, Michigan State University professor of psychiatry and counseling.

Doctors need to know and understand their own hangups when trying to educate patients. "What subjects or behavior cause the doctor to be uncomfortable or threatening?" he asked.

When physicians want to give information or instructions to patients they must first find out what the patient already knows about the medical situation or the proposed treatment, declared Professor Kagan.

During the process of giving information, the doctor may find out that the patient has misconceptions and may have faulty information, he said. He suggested giving patients information in small chunks and asking for feedback and questions. In providing patient education, he urged physicians to build new knowledge upon old, and to "work from the patient's conception".

Effective teaching, Professor Kagan said, includes use of visual and audiovisual aids, and considerable use of demonstrations.

Influencing the attitudes of the patient provides a real challenge to physicians, pointed out Professor Kagan. Again it is helpful, he said, to find out first what the patient believes and/or understands.

The physicians who are best at counseling patients, he said, are those who give power to the patient. "This also means learning to listen to patients."

Health Council Helps

Continuing medical education workshops and discussions about patient education and health promotion are being encouraged in Michigan by the Michigan Health Council.

Physicians active in programming for hospital medical staffs, for component medical societies and for specialty organizations can get assistance from Herbert A. Auer, executive vice president of the Health Council by phoning 517/337-1615.

The course at the recent MSMS Annual Scientific Meeting was organized for physicians and medical assistants by three closely related organizations. The Michigan Academy of Family Physicians approved the course for prescribed credit, and C. Edward Cotton, MD, Marcellus, was the course director.

MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

April 7 — Workshop for Accredited CME Providers, Long's Convention Center, Lansing, contact: Marce Ireland, MSMS headquarters, 517/337-1351.

April 8 — MSMS Conference on Sports Medicine, Plymouth Hilton, contact: Mert Scholten, MSMS headquarters.

April 14-15 — 1982 Michigan Conference on Maternal and Perinatal Health, Grand Plaza Center, Grand Rapids, contact: Katie Brewbaker, MSMS headquarters.

April 30-May 1-2 — MSMS House of Delegates, Westin Hotel, Renaissance Center, Detroit, contact: Richard Campau, MSMS headquarters.

May 3-5 — 56th Annual Convention MSMS Auxiliary, Grand Plaza, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

June 13-17 — Annual Meeting, American Medical Association, Chicago, contact: AMA, 535 N. Dearborn, Chicago 60610 (312/751-6000).

June 13-16 — AMAA Convention, Drake Hotel, Chicago, contact: Caroline Rich, MSMS headquarters.

June 30 — MSMS/INTRAV Rhine River Adventure (14 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

July 11-14 — The Council Midsummer Session, Grand Traverse Hilton, contact: Warren F. Tryloff, MSMS headquarters, 517/337-1351.

July 18 — MSMS/INTRAV Alpine Adventure (15 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

Other meetings

March 3 — "Legal Issues in Public Health", Michigan Public Health Association, Clare County Courthouse, Harrison, contact: MPHA, 517/332-7271.

March 31-April 2 — "The Life Savers", National Conference on Occupant Protection and Alcohol Countermeasures, Book Cadillac Hotel, Detroit, contact: Office of Highway Safety Planning, 7150 Harris Drive, Lansing 48913.

April 5 — Wayne County Medical Society 61st Annual Beaumont Lecture, Bon Secours Hospital, Grosse Pointe, contact: Wayne County Medical Society.

April 15-16 — Nursing Standards Seminar, Grand Rapids, contact: Julie Efaw, Joint Commission for the Accreditation of Hospitals Headquarters.

May 5-7 — Annual Meeting and Scientific Session, Michigan Chapter, American College of Surgeons, Grand Plaza Hotel, Grand Rapids, contact: Viola Heins, 517/337-1351.

May 20-22 — Michigan Association of Osteopathic Physicians and Surgeons, 83rd Postgraduate Conference and Scientific Seminar, Westin Hotel, Detroit, contact: D.A. Deshaw, Executive Director, Michigan Association of Osteopathic Physicians and Sur-

Continued on page 184

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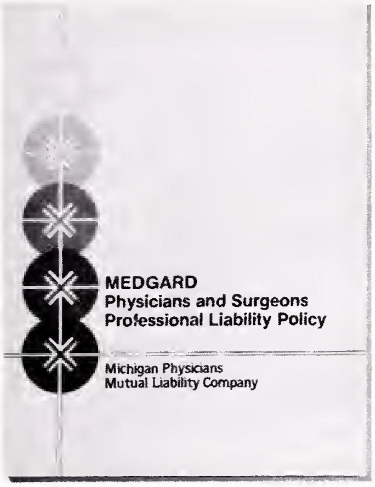

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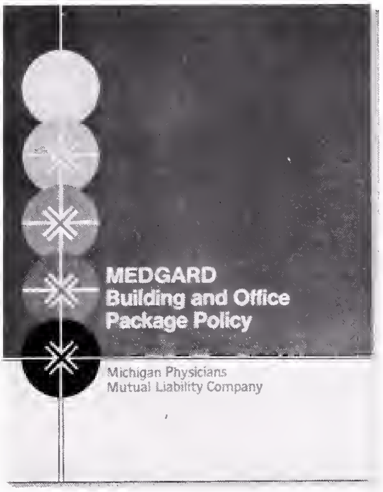

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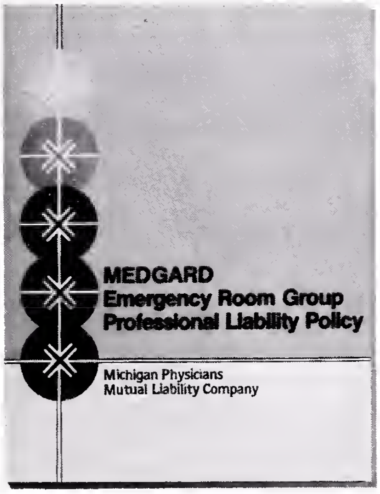

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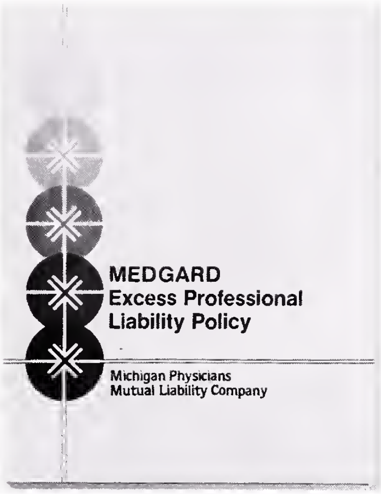

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MEETINGS/Continued

geons, 33100 Freedom Road, Farmington 48024, 313/476-2800.

June 1-3 — "A Look at Local Public Health in Michigan," Michigan Public Health Association, contact: MPHA, 1407 S. Harrison Road, Suite 340, East Lansing 48823.

June 25-27 — Michigan Association of Neurological Surgeons Annual Meeting, Birchwood Inn, Harbor Springs, contact: David Herz, MD, (616) 456-9507.

June 26-27 — Annual Meeting of the Michigan Orthopaedic Society, Hidden Valley, Gaylord, contact: Jerome Conrad, (616) 796-6721.

July 11-14 — Advances in Emergency Care, Ninth Michigan Emergency Medicine Assembly, Grand Traverse Hilton, contact: Catherine C. Sleicher (517) 332-6500. Deadline for submission of abstracts of original, unpublished scientific papers for presentation is May 1.

July 12 — Annual Membership Meeting, Michigan Chapter, American College of Emergency Physicians, Grand Traverse Hilton, contact: Catherine C. Sleicher, (517) 332-6500.

July 30-August 1 — Upper Peninsula Medical Society Meeting, Northern Michigan University campus, contact: Robert Raica, Director of Community and Public Relations, Marquette General Hospital (906-228-9440).

September 24-26 — Michigan Chapter American Academy of Pediatrics Annual Scientific Meeting, Grand Traverse Hilton, contact: Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018, (313) 553-3646.

Oct. 23 — Michigan Neurological Association Annual Meeting, Dearborn Inn, contact: Sheila Sheehow, MD, (313) 875-1913.

Nuclear war conference April 24

A symposium planned April 24 by the Wayne State University School of Medicine aims to educate physicians to the urgency and necessity of preventing nuclear war, and to describe the medical environment we would encounter should it occur.

The conference is scheduled all day at the Music Hall in Detroit and will offer five Category I CME credit hours.

"I urge every hospital to at least have a representative attend the conference," says James D. Fryfogle, MD, MSMS president and moderator of the conference. "This conference is about the last epidemic, for which there is no treatment but prevention."

Cosponsors include Henry Ford Hospital and Michigan State University Colleges of Human and Osteopathic Medicine. The symposium is organized by the Detroit and Washtenaw county chapters of Physicians for Social Responsibility, Inc., a non-profit organization mittted to educating physicians and the public about the medical aspects of nuclear war.

Symposium speakers will include Charles S. Stevenson, MD, WSU emeritus professor and chairman of obstetrics and gynecology, who was the first American naval officer ashore at Nagasaki in 1945.

For details, please contact the Division of Continuing Medical Education, WSU School of Medicine, (313/577-1180).

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DEATHS

Norman H. Amos, MD Battle Creek

Norman H. Amos, MD, Battle Creek orthopedic surgeon, died December 10. He was 81. He received his MD degree from the University of Michigan Medical School in 1926, and established his practice in Battle Creek in 1982. Doctor Amos served as chief of staff at Community and Leila hospitals and was physician for several Battle Creek industries before his retirement in 1968. He also volunteered his medical services for years at the Kimball Sanitorium, when it treated tuberculosis patients from throughout southwestern lower Michigan. In 1953, he was recognized by the Sanitorium patients as "doctor of the year." Doctor Amos served as a medical officer in both World Wars.

Regis F. Asselin, MD Kalamazoo

Regis F. Asselin, MD, died December 10 in Kalamazoo. He was 69. Formerly of Detroit, Doctor Asselin graduated from the Long Island, New York, College of Medicine in 1931, and served his internship at Providence Hospital in Southfield. He served in the Army Medical Corps from 1942 and 1946, then returned to Providence Hospital and later, private practice. He maintained his Detroit practice for 21 years.

Dorina S. Mercea, MD Coldwater

Dorina S. Mercea, MD, of Coldwater died December 17 at the age of 57. Doctor Mercea was a native of Romania. She came to the U.S. in 1969 and served her internship and residency in White Plains, New York and Jacksonville, Florida. Doctor Mercea moved to Coldwater in 1974 and became staff physician at the Coldwater Regional Center for Developmental Disabilities.

Edward C. Mosier, MD Pompano Beach, FL

Edward C. Mosier, MD, formerly of Otisville, died December 25 at the age of 74. He served as the community's doctor, pharmacist, and ophthalmologist from his office. Doctor Mosier was Genesee County coroner from the 1940s to the 1960s and served for a time as chief of staff at Genesee Memorial Hospital. Doctor Mosier was the first chief of general practice at McClaren General Hospital, where he helped establish

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the hospital's first pharmacy department. Upon his retirement from his 42-year practice, two thousand community residents honored him with a dinner.

Jean Paul Pratt, MD
Fort Lauderdale, FL

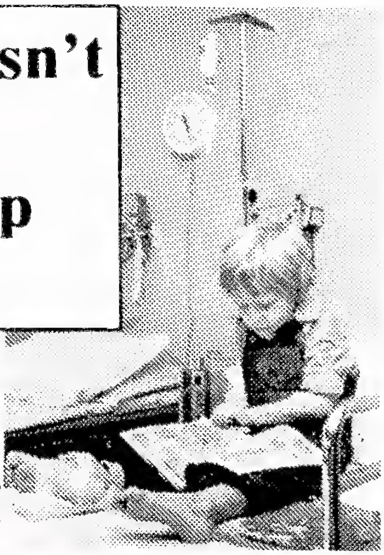
Jean Paul Pratt, MD, former chief of gynecology and obstetrics at Ford Hospital, died December 25 at the age of 99. Doctor Pratt, a founding physician of Ford Hospital, graduated from Johns Hopkins Medical School, then began a career that included delivering all of Henry Ford's grandchildren, performing field surgery duty with the American Expeditionary Force in World War I, and operating on Diamond Jim Brady, the legendary gourmand. Doctor Pratt performed surgery until age 85. He was founder of the Endocrine Society and the Central Association of Obstetricians and Gynecologists.

H. G. Yesayian, MD
Lathrup Village

H. G. Yesayian, MD, died December 21 at the age of 87. A general practitioner, Doctor Yesayian was the oldest staff member at Samaritan Hospital and until the time of his death maintained a busy medical practice that included house calls. A native of Turkey, he received his medical degree from the Detroit College of Medicine and Surgery, now Wayne State University, and was an active member of the Armenian Congregational Church.

Lloyd B. Young, MD
Suttons Bay

Lloyd B. Young, MD, internist and cardiologist, died December 22 at the age of 78. A 1927 graduate of the U-M Medical School, Doctor Young maintained a private practice and served Grace Hospital in Detroit until 1960. He was head of medicine and surgery at Traverse City Regional Psychiatric Hospital until his retirement in 1970. Doctor Young had served as a naval commander during World War II, and was a fellow of the American College of Physicians.



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Pennwalt	171, 172, 173, 174
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Stratton Cheeseman	177
Troy Biologicals	164
Upjohn	160
U.S. Army	158, 182
Watkins, Ross, Baines and Lamps	132
WSU School of Medicine Alumni	178

PRESIDENT'S PAGE

Seven County Committee doctors' voice in planning

By James D. Fryfogle, MD
MSMS President

I'd like to tell you about Southeast Michigan's "Seven-County Committee."

Its real name is the Seven-County Health Planning Advisory Committee to the Comprehensive Health Planning Council of Southeast Michigan (CHPCSEM). And the reason I tell you about it is that the Seven County Committee might be a model for problem-solving elsewhere, regardless of the arena.

So, what is it? Why does it exist? Who is on the committee? What does it do? These and more are the questions often asked.

Let me see if I can answer some of them for you.

The Seven County Committee was formed by action of all seven of the Southeast Michigan county medical and osteopathic societies in 1977, to monitor the actions of the CHPCSEM and their effect on the practice of medicine. Committee members came from Livingston, Macomb, Monroe, St. Clair, Washtenaw and Wayne counties.

The Federal Health Planning Act of 197 gave meager representation to doctors on their health systems agency governing boards.

As you know the act specified members of all boards and committees were to have a consumer majority. CHPCSEM decided the ratio of consumer to provider should be 57/43. In the provider group, doctors made up only five percent and less than half of these were in private practice.

The few stalwarts who helped organize AHOC-CHPC, and finally the HSA, like Sidney Adler, MD; Ralph Cooper, MD; Kenneth Ray, MD, and myself soon found there were not enough hours to keep up with the well-financed, bumbling, federal organization that was rapidly changing the face of medical practice in our area.

I petitioned the Wayne County Medical Society's Council for help. With the skillful architectural hand of Roger Mecum, and a splendid response from all of the county societies, the Seven County Committee was born.

Each group agreed to pay $2 per member to finance the committee, and we went to work. Our simple task of monitoring and review soon grew to opinion-making and a recognized voice of the doctor, which influenced the federal planning action.

We agreed to supply to any CHPC committee physician consultation without vote. We closely followed their published agenda and invited to our meetings the consultants they might employ — their committee chairmen, their officers or any members of subarea committees whose problem might influence doctors.

When CHPCSEM held public hearings, or when legislative committees requested opinions, the Seven County Committee spoke for the doctor.

We accepted the assignment from the Governor's office to plan for doctor displacement in the event of hospital closings. A large number of the technical work group for the second debedding cycle was made up of Seven County members.

We've been busy, and I think there is little doubt that the Seven County Committee has created a larger doctor voice and greater influence on government planning for health than we had with our meager representation in the CHPC organization.

Most pleasing to me is the large number of doctors who have obtained expertise in the health planning process. Any of our members could now testify, chair, or investigate a planning problem and many now head up their own county programs.

I still haven't answered many of the starting questions. We represent all doctors in the seven county area; but their societies receive all of our deliberations and can act independently or in concert.

To my knowledge the Seven County Committee has no official status. We are not a standing committee of any organization. But it has proved a most beneficial association of professionals in a critical area where we had no voice or way to go.

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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

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Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

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Dosage: Not recommended for infants less than two months of age.

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Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

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1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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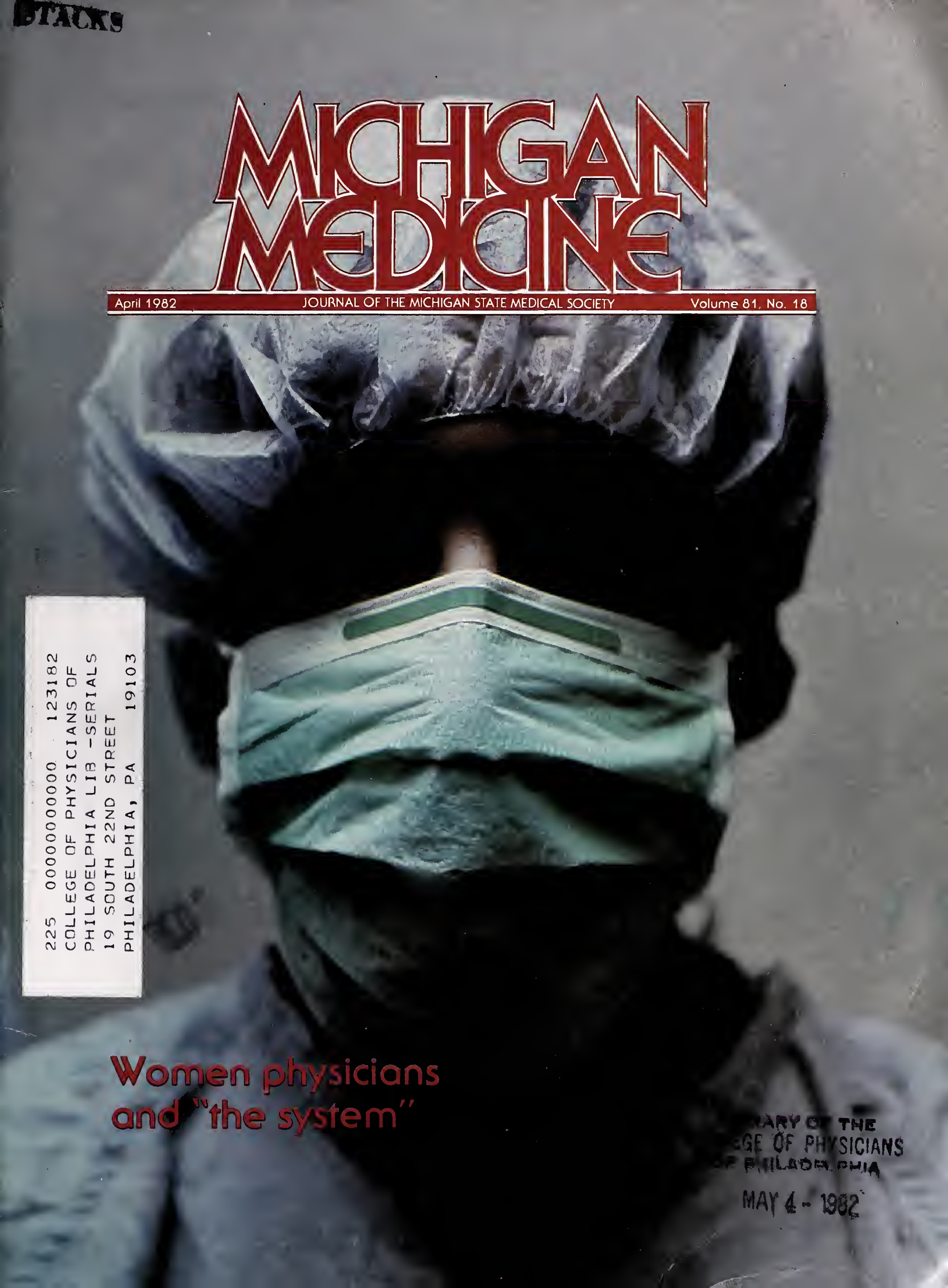
MICHIGAN MEDICINE

April 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 81, No. 18



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Women physicians and "the system"

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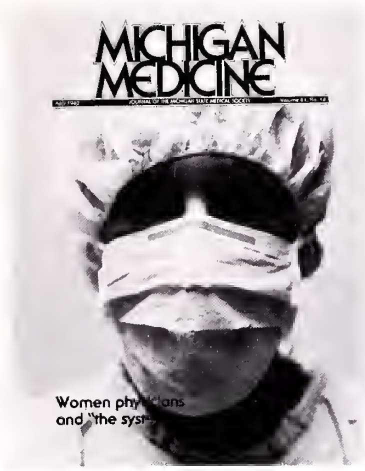


The modern-day female physician on our cover illustrates our special report promoting the coming MSMS Women Physicians Conference: "How to use the system." See page 196. **(Photo by Mert Scholten)**

MICHIGAN MEDICINE

April 1982, Volume 81, No. 18

Special report

196 To help women learn to assume and handle positions of strength and influence, MSMS will stage a Women Physicians Conference, "How to use the system," May 6 in Southfield; Linda Logsdon, MD; Ronald Lippitt, PhD; Susan Adelman, MD; Anna Broecker, MD; Mary Cretens, MD; Miriam Daly, MD; Winifred Oyen, MD, and Marjorie Peebles-Meyers, MD

Features

204 Former Michigan MD, herself female, studies women medical students' problems; Willah Weddon

208 Bill Burns was a gentleman: a eulogy; Kenneth H. Johnson, MD

210 Michigan deans describe medical schools' problems to legislators

225 Meeting the challenges of the 80's; Part II in a series

232 MSU researchers document physicians' difficulties with patients unlike themselves

Departments

192 In my opinion; Busharat Ahmad, MD

193 Letters

207 News

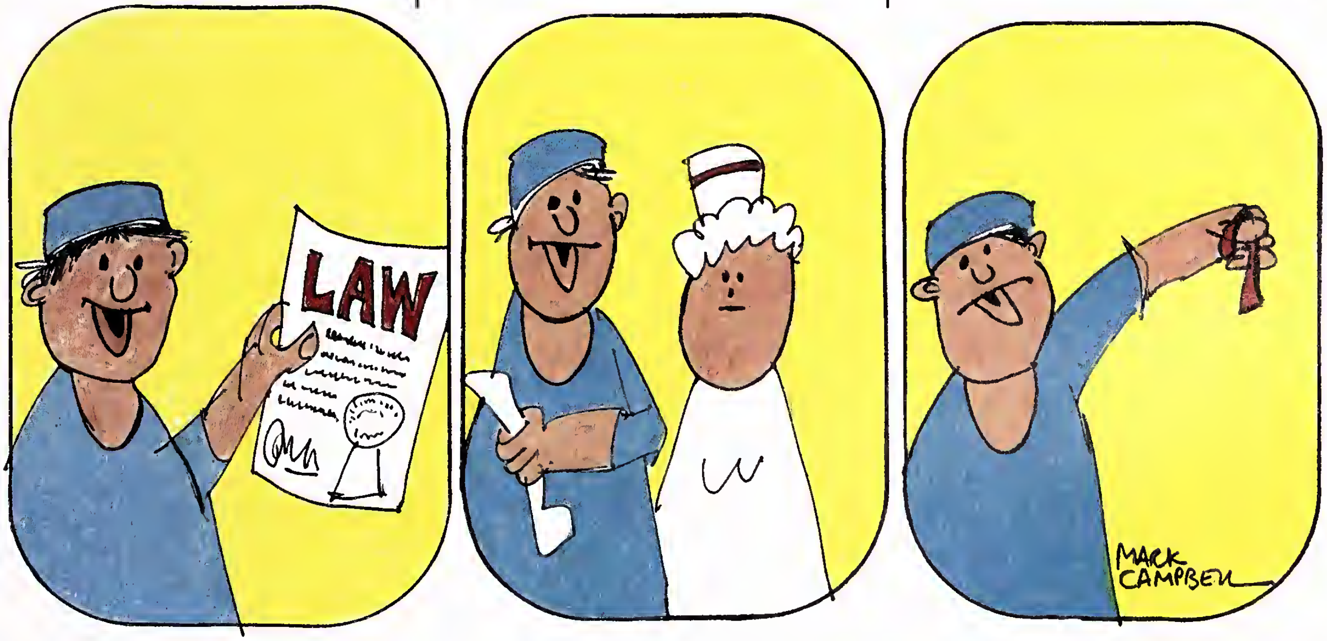
216 Category I courses

222 Meetings

234 Classified ads

235 Ad index

236 President's page; James H. Tisdel, MD



The new law forces cutbacks in health care of 50%.

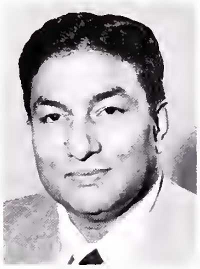
But what I don't understand is . . .

. . . Which half of the appendix do they want me to leave in?

IN MY OPINION

U.S. trails much of world in numbers of female MDs

By Busharat Ahmad, MD
Marquette



Enrollment of women in U.S. medical schools has steadily increased for the past 10 years. It still is not up to the level where it should be, in keeping with the percentage of educated women in our population and also the percentage of working women in our labor force. We all know that the acceptance of the female physician has been difficult not only for the general population but also for their male colleagues. This acceptance has improved over the last decade. This may be the sign of the times, the more broad point of view of male physicians or the women's equality movement in the country. But whatever it is, it is a leveling trend that we all welcome.

If we look at the participation of women in medicine, especially on the MD level, we find ourselves far behind in the ratio of female to male physicians as compared to some of the developing countries like India, Pakistan, Iran, Bangladesh, et cetera, and also some of the advanced countries like the USSR. In most of these countries female physicians make up to 50 percent of the total and even up to 70 percent in the USSR. Their experience has been very good and in general they have had no problems.

In those countries, female MDs work somewhat less than full time during the period of about five to 10 years after graduation because of family obligations. But even in those times it is their experience that the women keep their hand in, working as part-time or salaried physicians. This, considering the large number of female physicians in this age group, does not seem to pose a problem. In the USSR this dip in the curve is not very significant because the children are taken care of by the state and the mother can work full time.

In my opinion we are going to gain a lot by the increase in the number of female physicians in our country. The development may even be a sobering influence on some of our male colleagues.

Doctor Ahmad is an ophthalmologist and chairman of the MSMS Committee on Publications.

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Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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LETTERS

Consumers' needs

Elmer White's article in your January, 1982, issue ("MSMS Public Service Campaign to Help Medicine, Public Relate") was very informative. As director of the Department of Licensing and Regulation — the department of state government which both licenses and regulates physicians — I applaud your efforts to inform the public about what they need to know in order to make informed choices. Your pamphlet, designed to help travelers deal with health problems while away from home, is an excellent example of what can be done by the private sector to address consumers' needs. Future publications listed in Mr. White's article are elaborations of this theme.

Information about what providers do, and what consumers of their services can and should do, is invaluable. I hope you will make these materials widely available. Good luck in this important endeavor!

Silverenia Q. Kanoyton, Director
Michigan Department of Licensing and Regulation
Lansing

Help for disabled

The Michigan Protection and Advocacy Service is available to assist citizens with developmental disabilities to make successful application for benefits, services, programs, and opportunities especially intended for them or generically available to the general population.

In pursuing that mission, we need your assistance. Many doctors already refer patients to us that could benefit from our services, but most doctors don't even know we exist.

The P and A Service was created by mandate of the Congress and the Michigan Legislature. Aside from the mission described above, it seeks to help developmentally disabled citizens to accomplish maximum independence and to overcome wrongful denial of benefits and rights.

Michigan's P and A Service includes a small central office support team in Lansing and 14 branch offices at Department of Mental Health facilities. P and A Services includes a small unit of attorneys and a consumer coalition.

Physicians may write us for further information.

Mark Stroh
Director of Communications
Michigan Protection and Advocacy
Service For Developmentally
Disabled Citizens, Inc.
230 N. Washington Square, Suite 200
Lansing, 48933

Preventing blindness

We appreciate receiving copies of the racquet sports eye safety poster developed and distributed by the Michigan State Medical Society. Your association is to be commended on its efforts to reduce eye injuries to racquet sports players.

Members of the medical society may also find of interest and value the enclosed "Eye Protection Recommendations for Racquet Sports Players" developed by the National Society to Prevent Blindness. Copies of these, available from NSPB, should ideally be provided to all racquet clubs along with a poster. Also enclosed is a copy of our racquet sports eye safety poster.

Thanks again for the poster.

Dennis Hirschfelder
Director of Eye Safety Programs
National Society
to Prevent Blindness
New York, NY

Editor's Note: Physicians wishing copies of the NSPB recommendations may contact Mert Scholten at MSMS headquarters.

Course clarification

Thank you very much for the complimentary copy of the January 1982 issue of *Michigan Medicine* in which I was pictured on page 30. Both Doctor Honet, the course director, and I appreciate coverage of the course. However, I was disappointed with several aspects of the coverage.

Firstly, the course was entitled "Arm Pain and Dysfunction" with the "dysfunction" being the important aspect of the course and one which was very carefully and fully addressed. Secondly, the course was put on by Sinai Hospital of Detroit, Department of Rehabilitation Medicine, in conjunction with other physicians. This fact was omitted and I believe it would have been most appropriate and important to indicate. From the legend, as it is written, few people recognize the department or hospital from which the course originated.

Maury Ellenberg, MD
Director, Resident Education
Sinai Hospital of Detroit

PREVENTIVE MEDICINE FOR FAMILY PHYSICIANS

Wednesday, May 26, 1982
McGregor Conference Center
Wayne State University
Detroit, Michigan

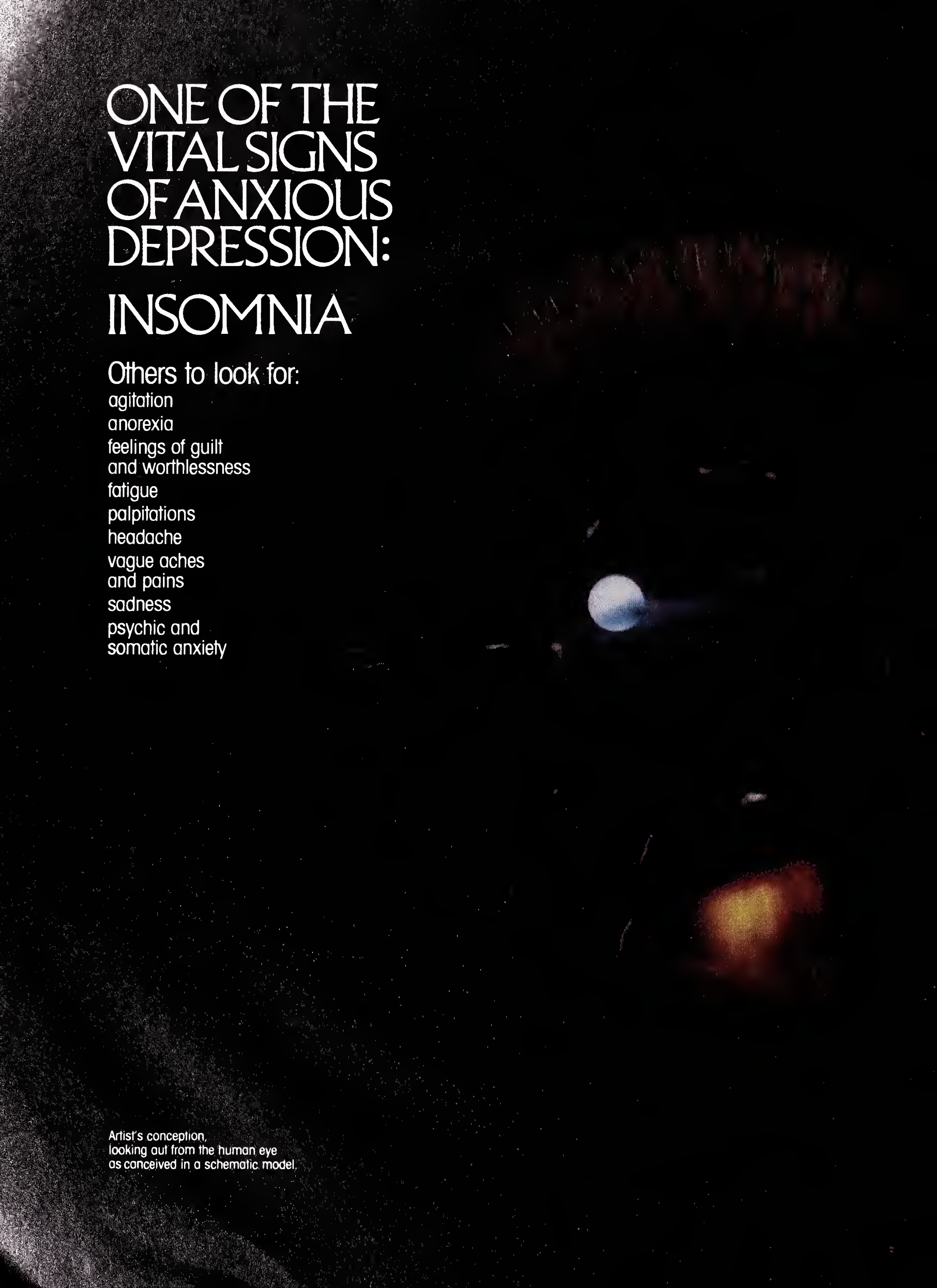
Morning Session:
Medical and Preventive Aspects of Alcoholism for Family Physicians

Afternoon Session:
Nutritional and Behavioral Approaches to the Prevention and Management of Vascular Disease, Hypertension, Obesity and Diabetes

Credit:
7 Hours C.M.E. Prescribed Credit
7 Hours Category I Credit

Cosponsored By:
Departments of Family Medicine, Wayne State University
Metropolitan Detroit Family Practice Residencies
National Council on Alcoholism — Greater Detroit Area

For detailed program and
registration form contact:
Division of Continuing Medical Education
Wayne State University
Suite 9B-32, University Health Center
4201 St. Antoine Boulevard
Detroit, Michigan 48201
(313) 577-1180



ONE OF THE VITAL SIGNS OF ANXIOUS DEPRESSION:

INSOMNIA

Others to look for:

agitation
anorexia
feelings of guilt and worthlessness
fatigue
palpitations
headache
vague aches and pains
sadness
psychic and somatic anxiety

Artist's conception,
looking out from the human eye
as conceived in a schematic model.

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LIMBITROL GIVEN H.S.: ONE OF THE VITAL SPECIFICS OF TREATMENT

Limbitrol brings a special—and specific—quality of relief to most anxious depressed patients. Insomnia, for example, responds with particular promptness. Other symptoms likely to respond within the first week of treatment include anorexia, agitation and psychic and somatic anxiety. And, as the depression and anxiety are alleviated, in many cases so are such related somatic symptoms as headache, palpitations, and various vague aches and pains.

Limbitrol given once daily h.s. may be the best approach

Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

Limbitrol® Ⓒ IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)
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Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine. Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50.

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Manati, Puerto Rico 00701

Special report

Michigan's women

By Linda Logsdon, MD
Southfield

"We invite you to join us for a unique conference . . . one exclusively designed to help women physicians understand, and more importantly, use 'The System' of organized medicine."

This is the invitation MSMS recently mailed to 1,000 women physicians in Michigan. This women physicians' conference, "How to Use The System," is scheduled Thursday, May 6 at the Michigan Inn in Southfield.

By sponsoring this conference, MSMS acknowledges an important change taking place in medicine. The number of women physicians is increasing dramatically. AMA statistics as of November 1981 reveal the national average for women physicians to be 12 percent, women residents to be 22 percent, and women medical students 27.5 percent. However, membership and participation of women physicians in organized medicine has always been disproportionately low compared to the total physician population. The number of women in leadership positions is even lower. It is crucial that this pattern change in order to maintain the viability of medical organizations.

This all-day conference is intended to confront this issue of participation and leadership by examining a number of questions. What factors most affect a woman's functioning in medicine? How does she relate to other women physicians and her male colleagues? How does she view herself in relation to organized medicine? What knowledge is needed to help her achieve comfort with "the system"! What are the issues in which she is personally interested? How can she use "the system" effectively to promote these issues?

To accomplish this ambitious task a format of small group discussions will be used, led by an experienced interdisciplinary team. Leader Ronald Lippitt, PhD, is a professor emeritus at the University of Michigan, having taught for 20 years in the fields of psychology and sociology. He has extensive experience in group process and has participated in leadership workshops for women physicians nationally. Eileen Rogers and Kathleen Dannemiller, both from Ann Arbor, are experienced in organizational structure, assertiveness training, and personal and professional planning. Physicians will serve as facilitators of each group and as resource people to provide information necessary to broaden knowledge and skills.

Participants are encouraged to register early as attendance will be limited. A number of places will be re-

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Doctor Logsdon is a psychiatrist and chairperson of the MSMS Women Physicians' Conference.

hysicians and 'the system'

served for women in residency training and medical school at a reduced rate. MSMS component societies, medical specialty societies, and medical schools are being contacted and asked to consider sponsoring the attendance of one or more of their women members.

Conference hours will be from 9 AM to 5 PM with a reception to follow. The cost will be $50 for the physician in practice, $25 for a resident and $15 for a student. With the registration, the participant is asked to respond to a questionnaire allowing for further tailoring of the conference content to the needs of the participants. The responses also will guide future endeavors.

The planning committee includes physicians Anna Broecker, MD; Miriam Daly, MD; Carl Gagliardi, MD; Vivian Lewis, MD; and Louis Zako, MD, along with staff, Vada Davis. They have labored with great enthusiasm.

Politics are an essential component of every profession. Women have a unique contribution to make to medicine as well as to the political process. It is hoped that this conference will be the first step toward achieving the goals of greater awareness, comfort, participation, and ultimately, leadership for the woman physician in the system of organized medicine.

Professional socialization latest barrier

More women than ever are entering medical school. But, after graduation, they're finding that the coveted degree is no guarantee of professional or financial success.

Subtle barriers to "professional socialization" are the latest form of discrimination against women physicians, says Carlotta M. Rinke, MD, writing in the *Journal of the American Medical Association*. "Nothing at all has been gained" if young women physicians can't participate in professional activities and claim the academic and financial rewards they deserve, says Doctor Rinke.

Professional socialization consists of learning roles, values, responsibilities and attitudes considered important and appropriate to a profession. Successful professional socialization results in acquiring a positive self-image of competence and acceptance by peers, she says.

Women physicians are finding many of the traditional routes to professional socialization closed to them, Doctor Rinke claims. They tend to be excluded from the informal, fraternity-like network of male physicians through which contacts are made and information is exchanged. This hampers their ability to operate in the power structure of academic and private medicine, ultimately limiting their upward mobility and incomes.

Women physicians also suffer an identity crisis when they attempt to reconcile their womanhood with the traditional masculine stereotype of a medical practitioner: assertive, ambitious, independent and dominant. When a woman physician acts in this manner, according to Doctor Rinke, she runs the risks of being called a "bitch" or a "castrating female."

Lack of acceptance by male physicians also can stunt the growth of a woman physician's professional identity. Doctor Rinke cites studies revealing that as many as two-thirds of practicing male physicians do not accept woman as peers.

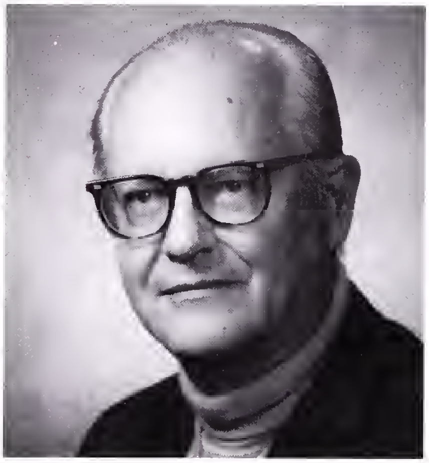
Compounding these problems are the lack of female role models in academic and private medicine and an ironic prejudice among women physicians that makes them devalue each other's professional competence. This occurs at a time when women could benefit from supporting each other and sharing their common experiences.

Also, says Doctor Rinke, it is still enormously difficult for women physicians to interrupt their professional lives for childbearing without having to drop out of competition for the top careers in medicine.

Only in fully recognizing and dealing with all these obstacles, Doctor Rinkes warns, "will the medical profession really tap the full potential of its women members."

MSMS conference to focus on two challenges to committed professional women

By Ronald Lippitt, PhD
Ann Arbor



Doctor Lippitt

The MSMS workshop on May 6 will provide a chance to work on two of the challenges which come into focus every time I work with a group of committed professional women — lawyers, physicians, business managers, college teachers, social workers, social agency administrators, and others.

Multiple roles

One challenge is that of dealing creatively with the multiple role demands of being a fully committed professional practitioner, a wife, mother, and active community citizen.

There are several patterns of dealing with these often competing demands:

1. One pattern is to define one loyalty as "the priority" and to screen and subordinate the other expectations.

2. A second pattern is the "balancing act" of trying to please all the voices equally; ie, living a life of continuing inner conflict and compromise.

3. A third pattern is to reject "their right to control me" so a "plague on all their houses; I have a right to do what I feel like."

Doctor Lippitt is professor emeritus at the University of Michigan and writes and lectures on planned change theory strategies and techniques.

None of these are satisfactory patterns of solution, and they leave one feeling very alone and exposed as a problem-solver.

The more difficult, but more creative and satisfying solution is to listen to all the expectation voices as providing valid data, and then getting those significant others involved in listening to and understanding your needs and getting them involved in your time management and loyalty management challenges.

Building an external support system is really the only way to effectively deal with the internal conflicts of multiple loyalty demands which often become complementary rather than conflicting if you build your significant others into a collaborative support system. We'll be working on this in the workshop.

Active risk-taking

Turning to the other challenge — active risk-taking, we find we are dealing with a mixture of assumptions: that "they will say 'no'," that "they will ignore or reject my input," that "they will use me as a token female," that "it will require more energy than I want to put into it."

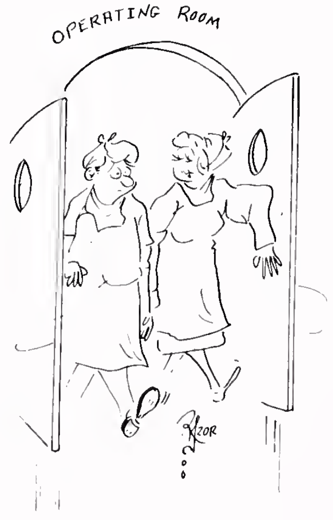
In a recent womanpower workshop which I co-led, we discovered that in a majority of the initiatives the women wanted to take, they were assuming a high probability of "No" responses, rejection and resistance. They were reacting to this assumption rather than working actively on the skills of influencing more effectively and successfully.

We did much skill practice, rehearsing anticipated situations, with great help from several male colleagues. The followup feedback was that there was great surprise at the readiness to listen and to be collaborative.

The skill practice helped, but clearly also there were many incorrect assumptions about rejection and resistance. This will be a challenge for us to work on in our May 6 session.

We also may want to explore another trend which seems supported by some of the left brain/right brain research, which suggests that differences in female and male socialization may mean that in some situations, and for some tasks, males and females have different, complementary resources, superior to any unisex combinations.

It's my hunch that the advantages of complementary male-female collaboration will be one of the exciting human resource developments of the next decade.



"That's what I like!! . . . A woman who can tell a male chauvinist doctor what to do with his instruments!!"

Michigan high on list of female MDs in training and in practice

The District of Columbia leads the 50 states and possessions in the percentage of physician population constituted by women. Its 764 women physicians make up 18.4 percent of all physicians within the District, proportionally the highest in the nation.

Michigan is not a leader, but is high on the list for percentages both of practicing physicians and of physicians-in-training who are women.

As of November, 1981, the national average for women physicians (federal and nonfederal) was 12 percent. The individual state percentages range from 4.5 percent (Idaho) to 16.7 percent (New York).

States with less than 7 percent women physicians are Idaho, Montana, North Dakota, South Dakota, Nevada, Utah and Wyoming. The leaders, all with more than 14 percent women physicians, are Delaware, Maryland, Massachusetts, New Jersey, Illinois and New York.

Among the highest on the list were the U.S. possessions, including Puerto Rico (15 percent), the Pacific Islands (15.6 percent) and the Virgin Islands (17.9 percent).

Interestingly, when the figures are broken down to include only residents-in-training, the Virgin Islands fall to last on the list; of the three residents-in-training counted there, not one is a woman. But the Pacific Islands retain their leading position with 100 percent — or both — of the two residents-in-training counted there being women.

Women Residents-in-Training as a Percentage of the Total of all US Residents-in-Training (Federal and Non-Federal), by State November 30, 1981

22.0	National Average
-0-	Virgin Islands* (3 total)
11.4	APOs and FPOs
11.7	North Dakota
13.8	Vermont
15.5	Alabama
15.6	Montana
15.8	Florida
15.8	Louisiana
16.3	Arkansas
16.6	Kansas
16.7	Tennessee
17.0	Iowa
17.1	South Dakota
17.3	Oklahoma
17.9	West Virginia
18.1	South Carolina
18.3	Georgia
18.3	Texas
19.0	Alaska
19.0	Minnesota
19.6	Virginia
19.8	Arizona
19.9	Mississippi
19.9	North Carolina
20.0	Colorado
20.1	Wisconsin
20.2	Missouri
20.4	Nevada
20.6	Indiana
20.8	Kentucky
20.8	New York
20.9	Hawaii
21.2	Idaho
21.5	Maine
21.5	Ohio
22.1	Michigan
22.4	New Jersey
22.4	Vermont
22.4	Washington
22.5	California
22.9	Maryland
23.0	Nebraska
24.1	Oregon
24.6	New Mexico
24.9	Pennsylvania
25.5	Connecticut
25.7	New Hampshire
26.1	Illinois
26.5	Wyoming
26.7	Massachusetts
27.2	Rhode Island
27.7	Delaware
30.3	Puerto Rico
31.3	District of Columbia
100.0	Pacific Islands** (2 total)

Women Physicians as a Percentage of the Total of all US Physicians (Federal and Non-Federal), by State November 23, 1981

12.0	National Average
4.5	Idaho
4.6	Montana
5.4	North Dakota
6.0	South Dakota
6.1	Nevada
6.6	Utah
6.9	Wyoming
7.6	Arkansas
8.0	Alabama
8.0	Florida
8.0	South Carolina
8.1	Nebraska
8.3	APOs and FPOs
8.5	Iowa
8.6	Tennessee
9.0	Arizona
9.0	Maine
9.0	Mississippi
9.0	Oklahoma
9.1	Indiana
9.3	Georgia
9.4	Oregon
9.5	North Carolina
9.6	Wisconsin
9.8	Texas
9.8	Washington
9.9	Colorado
9.9	Louisiana
10.1	Kansas
10.3	Kentucky
10.3	New Hampshire
10.4	Minnesota
10.9	West Virginia
11.2	Missouri
11.4	Virginia
11.7	California
11.8	Rhode Island
12.2	Ohio
12.2	Vermont
12.4	Connecticut
12.6	New Mexico
12.8	Hawaii
13.0	Alaska
13.1	Michigan
13.5	Pennsylvania
14.3	Delaware
14.8	Maryland
14.8	Massachusetts
15.0	Puerto Rico
15.4	New Jersey
15.6	Pacific Islands
15.8	Illinois
16.7	New York
17.9	Virgin Islands
18.4	District of Columbia

What does it take to be successful within the medical

Susan Adelman, MD, Southfield
Doctor Adelman is a pediatric surgeon on several Detroit hospital staffs, is secretary of the Wayne County Medical Society and editor of the Detroit Medical News. She is on the Blue Cross/Blue Shield of Michigan board of directors and its Professional Relations Committee, and is a fellow of the American Academy of Pediatrics and the American College of Surgeons.

If the term medical system refers to the practice of medicine, the qualifications will be those of any good doctor. If by system you mean organized medicine, the qualifications would be those of a person who works well in organizations, has political instincts, and is concerned with the sociology, economics and goals of medicine.

Where a woman fills a much-needed gap in qualifications or talent, a woman may be well accepted and may develop a comfortable working relationship with her peers. Where a woman is in direct competition with her male peers, it is apt to be even more difficult for her than it would be for a man in a comparable position. This is true both in establishing a practice and in establishing oneself in organized medicine.

The big difference is that establishing a medical practice means direct, tangible rewards with a practical economic significance. The rewards, however, of being involved in organized medicine tend to be more intangible and tend to be a matter of self-esteem rather than monetary importance. Predictably, therefore, competition will not be as keen to carve out a role in organized medicine as it will be to build a practice in a highly competitive field.

Anna Broecker, MD, Grand Rapids
Doctor Broecker is associate pathologist with Blodgett Memorial Medical Center and a delegate to the MSMS House of Delegates. She is past president of the Kent Medical Foundation and former secretary-treasurer and director of the Kent County Medical Society. She is a fellow of the American Society of Clinical Pathologists and of the American College of Pathologists.

Opportunity is here for women physicians to get involved, as it has never been before. Organized medicine is very much aware of the poor participation record of women physicians, their scarcity in leadership positions and inadequate input.

It is an exciting and opportune time to be a woman in medicine and we need to take advantage of this. There are many concerns, some unique to women physicians, that need our input, e.g. more flexibility in medical training programs, job sharing, tax benefits for children and household expenses

Support your county society by regular attendance and participation.

MSMS provides invaluable support for us and needs our support.

Last, but not least, I feel strongly about supporting the American Medical Association. The AMA effectively represents our issues on the national level, and provided a sufficient number of our colleagues support them, will continue to do so whether or not you as an individual belong. If you don't belong, why should you be a parasite of the system?

I feel if you support organized medicine and give it your input, it will work for you.

Mary L. Cretens, MD, Gladstone
Doctor Cretens is medical director of the Delta-Menominee District Health Department, and has served on governing and advisory boards for the Michigan Health Officers Association, Michigan Board of Medicine, Services for the Aging, University of Michigan Medical School Alumni and area health systems agency.

"It takes more effort as time goes by to work successfully and efficiently with the medical system. The system continues to grow both in numbers and diversity, with a greater tendency for duplication of services and the fragmentation of these services.

"One needs to listen with an open mind, even though this is hard to do, and attempt to synthesize the best possible out of this for the patient without maximizing use of scarce resources. The more one can learn from many sources will be helpful in making these tasks easier. It takes more than just medical information to work through patient problems successfully."

system?

Miriam S. Daly, MD, Albion
Doctor Daly practices pediatrics and obstetrics in partnership with her husband, Harold L. Daly, MD. She is chairman of the Obstetric-Perinatal Task Force of the Michigan Academy of Family Physicians Health Services Commission; a member of the MSMS Committee on Maternal and Perinatal Health, trustee of the Calhoun County Medical Society and board member of the Perinatal Association of Michigan.

The most important things a woman (or man) physician must do to be successful in medicine are to get good training, try to keep up-to-date, and devote oneself to good patient care. The less she worries about being a woman and the more she shows concern for doing a competent, conscientious job, the more successful she will be working with the system.

It is important to get along with co-workers, doctors, nurses, technicians and hospital or office personnel. One way to do this is by showing respect and concern for them, their opinions, and their efforts. A second way is by getting to know them informally by regularly attending meetings and social gatherings where they are present. It is important for the woman physician to establish herself as a member of "the group".

She must be willing to contribute her share to hospital and professional committees.

My secret of being able to combine practice and family hinged on two people. The first was my physician-husband who encouraged me to continue medical practice and understood what was involved. The second was a devoted, loving housekeeper.

Winifred Oyen, MD, Midland
Doctor Oyen is health officer/medical director of the Midland County Health Department, member of the MSMS House of Delegates, and president-elect of the Michigan Health Officers Association. She is a member of the American Public Health Association and American Geriatrics Society.

A physician is first of all a person — either male or female. Each of us is one individual and our gender is part of that individuality.

Some individuals have more interest in the system. Some do not realize they are part of the system. Some of those who are interested find the time to become involved in organized medicine. Some do not become actively involved because matters of greater priority demand their time and attention.

Being active on medical staff committees in local and state societies, PSROs, HSAs, etc. takes time and energy. The people who are involved in these activities have to be sure that involvement is worth the time and energy required.

The people chosen to serve in these capacities demonstrate their interest and willingness to work — but they do not choose, appoint or elect themselves.

It is a privilege to be chosen by one's peers to represent them. It is a challenge to work in the medical system.

Marjorie Peebles-Meyers, MD
Doctor Peebles-Meyers is director, Medical Unit, Ford Motor Company World Headquarters. She was an MSMS delegate 13 years, an AMA alternate delegate; is past president of the Michigan Diabetes Association, and Michigan unit, American Medical Women's Association; and currently is trustee of the Michigan cancer and infectious diseases foundations.

To my younger colleagues who would participate in society affairs I say:

1) Join your local county medical society — whether we like the concept or not it is our "union." The proliferation of specialty societies, hospital courses and the legal requirement for CME have to a large degree diminished the educational function of the local units. The political and socio-economic functions not only remain but also have become increasingly important.

2) Accept and/or seek committee involvement. Such can be limited to your available time and energy and often proves enlightening.

3) Prejudice still exists, and probably always will, in some areas against sex, race, background or whatever. It is important for each of us to operate as if such does not exist. Do not allow the problems of others to set the limits of your development, interest or involvement.

Register today!

MSMS Conference for Women MDs: "How to Use The System"

Thursday, May 6, 1982
Michigan Inn, Southfield

MSMS invites you to join us for a unique conference exclusively designed to help women physicians understand, and more importantly, use "The System" of organized medicine.

Never has there been a more exciting and opportune time to be a woman in medicine. Patients are seeking our services in ever greater numbers, more women students and residents will soon increase our ranks dramatically. Many organizations, like MSMS, are actively pursuing women members to participate on committees.

In spite of these opportunities, our influence and presence in organized medicine remain sorely inadequate, by any standards. Could this be due to a lack of appreciation of how crucial our unique input is to the system, or a lack of knowledge of how to utilize the system for our own purposes, or perhaps a misconception of how much time is involved?

Join us on May 6. We will begin to learn how to influence medical organizations, legislation, and public opinion: how to organize and run an efficient committee, even how to be president of MSMS. More important, come and meet other women physicians, and establish a liaison with those of similar interests. Help identify areas in which we may help each other.

Conference details:

- — Michigan Inn, Southfield Michigan (at Northland)
- — Registration begins at 8:15 a.m.
- — Conference hours — 9 a.m. to 5 p.m.
- — Linger-longer Reception — 5 p.m.

Workshop process:

The session will run from 9 a.m. to 5 p.m., with small groups working with a facilitator at tables. Lunch will be served as part of the workshop experience. The actual sessions will be developed from the issues, concerns, needs, and burning questions check sheet the participants will have returned to the planning committee.

Workshop leadership:

The leadership for this session will be provided by (1) *Ronald Lippitt,* professor emeritus, The University of Michigan, leader of Women Power labs, workshops for medical women for AMWA, and "influencing upward" workshops for the Michigan Department of Social Services; (2) *Eileen Rogers,* nurse counselor at the University of Michigan Hospital, and (3) *Kathleen Dannemiller* organization consultant in business and education, currently the assistant to the vice president for student services at The University of Michigan.

Please return to:
Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823

Yes, I want to attend the MSMS Women Physicians Conference: How to Use "the System," Thursday, May 6, 1982, at the Michigan Inn, Southfield.

Enclosed is my check for the registration fee:
(check category below)

________ $50 practicing physician

________ $25 medical resident

________ $15 medical student

Name ________________________________

Address ________________________________

Date ________________________________

An added complication... in the treatment of bacterial bronchitis*

Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin-Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

200066

More women admitted to medical school, facing same old problems?

By Willah Weddon Stockbridge

Although the number of women entering medical schools across the nation has increased approximately three-fold within the past 12 years, problems they encounter while in training may very well remain the same.

Karen S. Johnson, MD, is making it her job to find out. A 1976 graduate of Michigan State University's College of Human Medicine and a native of Flint, Doctor Johnson received a $20,000 fellowship from the National Fund for Medical Education while completing her four-year psychiatry residency in June, 1981 at MSU.

This enabled her to begin research last September at the Univeristy of Illinois College of Medicine's Center for Educational Development in Chicago.

Special concerns

"I'm looking at the day-to-day experiences for women students in medical schools," she said during a telephone interview with *Michigan Medicine*. "There are special concerns women have that men don't."

"The entire process of identification is a complex one," she said. "For one thing, medical students select certain qualities in the physician they are working with and identify with these."

"When most of the instructors are men, it may alter the process of identification for women," she explained. She added that a woman medical student may experience feelings of isolation as a result.

"Such feelings may contribute to a woman seeming like an outsider in her own profession and may diminish her full satisfaction as a physician." she said.

To emphasize her concern, Doctor Johnson pointed out that in 1979 there were no female deans of medical schools and women physicians constituted only 1.2 percent of department chairpersons, 3.5 percent of full professors and 5.2 percent of associate professors on medical school facilities.

"These statistics are still approximately the same today," she said. In her application for the research grant, Doctor Johnson suggested that in the capacity of clinical educator and researcher, she could serve as a role model for women medical students and that alone would be a step in helping them.

Doctor Johnson is not looking for discrimination in her research, she said. There are simply 'built-in' conditions which do not exist for all students but which may create particular problems for female students in medical schools. If she can help medical educators understand the particular dilemmas of the women, she feels her time in research will be well spent.

"I hope also to uncover some strategies for facilitating the successful integration of the demands of medicine with oft-times presumed conflicting demands of being a woman," she said.

New field

There is no question that what Doctor Johnson has embarked on is an entirely new field of research and her background has prepared her well for the undertaking. Her pre-medical training was acquired at the University of Michigan. After obtaining her medical degree at MSU she was on the faculty for two years with the Department of Family Practice and also taught during her residency in MSU's Department of Psychiatry.

During these years, the unmarried and youthful doctor has pursued her interest in areas of research in health education for consumers, medical education, and women's health; including psychotherapy for women, normal female adult development and women psychiatrists as ob/gyn consultants. She also served as an editor for a consumer magazine and lectured frequently in Michigan on stress-related topics.

Ms. Weddon is a Lansing-area free-lance writer.

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VA Study[1]

- 450 patients studied
- Mild to moderate hypertensives
- Comparison of propranolol and reserpine for Step-2 antihypertensive therapy
- **Conclusion:** when added to a thiazide diuretic, reserpine was effective in a larger percentage of patients (88%) than was propranolol (81%)!

HDFP Study[2]

- More than 10,000 patients studied
- Conducted at 14 centers over 5 years
- Proved that compliance with Step Care lowers death rate from all cardiovascular causes
- **Conclusion:** reserpine-thiazide regimens were *preferred* for Step-2 therapy, and were deemed effective, without significant adverse effects!

MRFIT Study[3]

- 6-year, 12,000-patient study, to be completed in 1982
- Assesses factors that may increase risk of cardiovascular disease
- Preferred Step-2 regimen: reserpine-thiazide
- **Full year's data:** reserpine is causing less depression than methyldopa, diuretics, or placebo!

That's why the combination in

Salutensin®

(hydroflumethiazide 50 mg/
reserpine 0.125 mg)

Is the preferred Step-2 regimen

Please see references and brief summary of prescribing information on adjacent page.

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Brief Summary of Prescribing Information (12) 10/27/78
For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy—Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ADVERSE REACTIONS

Hydroflumethiazide—Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine—Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

The usual adult dose of Salutensin is one tablet once or twice daily. If a smaller amount of thiazide diuretic is desired, Salutensin-Demi, one tablet once or twice daily can be given.

SUPPLIED

Bottles of 10 and 1000 scored tablets.

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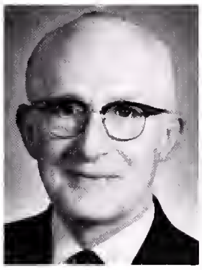
NEWS

By Sheri W. Greenhoe
East Lansing

Krull


Shaffer

Tomlanovich

Young

Joseph R. Lentini, MD, Grand Rapids, charter member of the Michigan Association of the Professions, has been elected to its board of directors. The Association's goal is to advance the ideals of professionalism through education, research and publicity. . . . **Joseph A. Sentkeresty, MD,** Grand Rapids, trustee of the American Society of Internal Medicine, was recently awarded fellowship in ASIM's Ancient Elliptical Order of Alligators. Representing ASIM, Doctor Sentkeresty spoke at the annual combined meeting of the Wisconsin Society of Internal Medicine and the Wisconsin Chapter of the American College of Physicians, as well as the Michigan Society of Internal Medicine and the Michigan Chapter of the American College of Physicians. . . . **Joseph Ponka, MD,** Detroit, is new president of the Roy D. McClure Surgical Society. . . . **John W. Rebuck, MD,** Detroit, recently received an Alumni Merit Award from Creighton University, recognizing Doctor Rebuck's "outstanding work in medicine and medical research." . . . **Joseph H. Shaffer, MD,** Boynton Beach, FL, formerly of Detroit, was honored by the American College of Physicians — Michigan Chapter for his "loyalty and long-standing membership." Doctor Shaffer, founder of the Allergy Division of Henry Ford Hospital in 1946, also was honored by the University of Chicago Medical Association for 50 years of service to mankind. He earned his MD from the University in 1927. . . . **Shiro Fujita, MD,** Detroit, won first prize at the American Academy of Otolaryngology conference for a scientific exhibit on a new surgical approach to treatment of sleep apnea. Since its development, the new technique has been learned and practiced across the country. . . . **Edward A. Krull, MD,** is new president-elect of the American Society for Dermatologic Surgery. . . . New officers of the Michigan Dermatologic Society include **George R. Mikhail, MD,** Detroit, president, and **Alejandro Moral-**

Ms. Greenhoe is editorial secretary for *Michigan Medicine.*

Continued on page 218

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Bill Burns was a gentleman

By Kenneth H. Johnson, MD
Lansing

Mr. Burns

As you know, the word eulogy comes from the Greek — meaning "good language, praise, blessing", "a set ovation in praise of a deceased person."

When asked by *Michigan Medicine* to write a eulogy for Bill Burns, I accepted without time to think, then had second thoughts. Why a eulogy? Those of us who knew him, worked with him, laughed with him, need no words of mine to recall what a great guy he was. Those of the younger generation will only accept that this is Ken Johnson's opinion — no more, no less. But then I thought — who better to try?

Dave Siegel said to me recently, "You know we humans have a real communication problem — we may have the greatest respect and good opinion of a person, and never tell them so."

Over the years that I knew Bill Burns, I can't recall that I ever told him he was a great guy. I'm sure I must have complimented him on a particular job; but I guess we all expected nothing less from Bill.

Doctor Johnson is past president, Council chairman, and secretary of MSMS.

Nobleman

Bill Burns was one of God's noblemen — deeply religious, but never using his religion as a goad to prod others. He was dedicated to professionalism in its highest sense — he expected high standards of himself and never doubted that those around him had the same ideals. With a handicap which would make many of us give up without a struggle, he mastered many accomplishments; most obvious was his ability to play the piano, which he did well. He had a delightful sense of humor and his hearty laugh would make us aware that Bill was nearby before we would see him.

One of the things that I enjoyed with Bill were the times we traveled together to MSMS meetings. He was an artful conversationalist, and there seemed never a subject in the realm of human endeavors and understanding that he did not appreciate and voice his appreciation . . .

He was quite a gourmet — one of his joys during strawberry season was a breakfast dish of fresh strawberries swimming in fresh orange juice, sprinkled with a little powdered sugar. This small item of food seemed to make his day.

I am purposefully leaving out Bill's specific accomplishments, since these will be covered elsewhere. A eulogy to Bill would be inconsequential if we did not speak of his wife Jo and his daughter, Missy. In certain respects, a marriage is a fragile thing. Pomp and circumstance, social pressures, all religious blessings, all of anything and everything in the world cannot make it work unless the individuals, woman and man, desire and strive to make it work.

Bill's was in truth a marriage that worked. Jo and Bill were deeply in love. As a result, their daughter Missy was born in this loving environment. Missy has carried on, with her husband Frank Mack, MD, this same tradition of family and personal love.

Intellectual

Bill Burn's intellect and his unusual skills in organizational matters were, of course, brought into sharp focus during his 29 years with MSMS. Those of us who were a part of the organizational structure of the Society will remember Bill's clout in parlaying his knowledge on a specific matter into an incisive evaluation. He would provide a substantive run-down of options available so that a decision could be made by individuals or groups. Officials, Council, House of Delegates, the state society members were keenly aware of his valuable contribution to its membership. They paid tribute to Bill on his retirement as executive director by appropriate recognition, with the gift of a car and a notebook containing 500 letters from physicians and others who knew Bill and his contribution to MSMS and the health field.

It is obvious that I was, and am, a fan of William J. Burns — Bill. I never heard Bill bad-mouth anyone. If he disagreed, so be it; but it was never a personal thing. I never heard him belittle anyone. Although he had superior intelligence, he did not use it to put anyone down. He never misrepresented, never gilded the lily, nor did he hang a wreath on a project because he didn't like it.

I started out by saying Bill was one of God's gentlemen — I finish by saying he was an all-around man among men and a delightful friend of mine.

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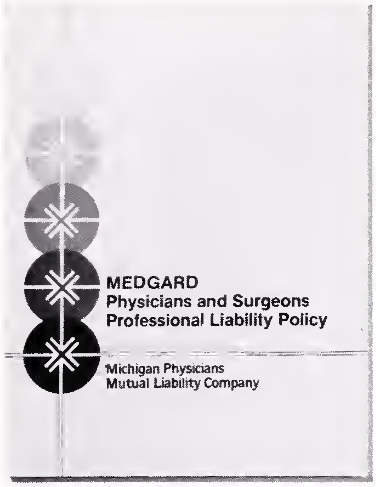
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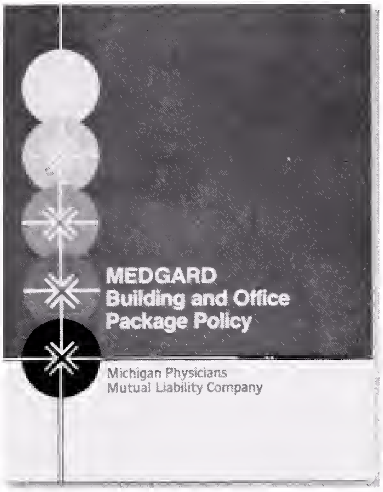
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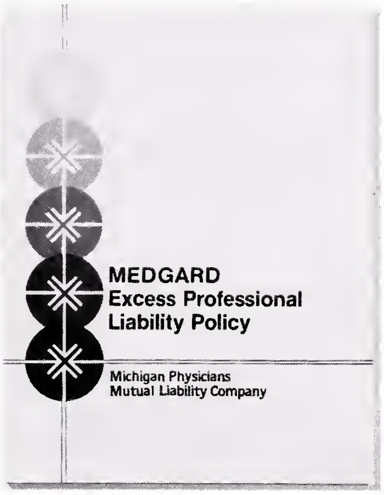
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Aid gone, only wealthy will apply to medical school

By Linda Morningstar
Lansing

Considering the burgeoning costs of health care, ought Michigan's up-and-coming physicians be required to study cost containment?

- Should medical schools' curricula be designed to respond to societal needs?
- Who gets into medical school? Can admissions criteria be geared toward bringing more minorities into medical school? With the drying up of sources of financial aid, will only the wealthy be able to afford to become physicians?
- Is there some way that medical schools can provide incentive for more physicians to practice in areas that are medically underserved?
- Can the four medical schools in Michigan, each with a distinctive mission, speak with a single voice regarding funding priorities and public policy in medical education?

These and other pressing questions in medical education were discussed in an afternoon workshop of legislators at Michigan State University on March 1. Hosted by the Michigan Medical Schools' Council of Deans, the session was requested by State Senator Edward Pierce and State Representative Raymond Hood, as a followup to State Health Plan hearings.

Most of the principal deans and administrators of Michigan's four medical schools were on hand (the University of Michigan, Wayne State University, Michigan State University's College of Human Medicine and MSU's College of Osteopathic Medicine).

Here are highlights of their answers to a few of the questions asked by the legislators and some of the major issues discussed:

Deciding what is taught

Are medical school curricula responding to societal needs?

Increased technological knowledge alone — advances in pharmacology, biochemistry, genetics, and cellular biology, for example — are burdening the medical student's study load, says Norbert Enzer, MD, associate dean for academic affairs in MSU's College of Human Medicine. "Still, to the extend possible, medical schools do revise the curriculum to meet social needs, adding courses in such areas as nutrition, substance abuse, aging, ethics and human values, and the role of the behavioral sciences in health."

Are medical students studying cost containment?

Most medical students are offered courses to study and compare the differing costs of various treatment choices and to study all of the costs involved in a single patient's regimen.

"Most students' response to the cost containment issue is one of surprise," Enzer says. "They're surprised by the costs and surprised at how little difference an expensive clinical diagnostic procedure may actually have on the quality of the treatment choice."

Are there formalized ways for "outsiders" to have a say about what is taught in medical schools?

"Even without soliciting it, we get plenty of input," says Myron Magen, DO, dean of the MSU's College of Osteopathic Medicine. "There are both formal and informal channels: medical students participate on curriculum committees; alumni are surveyed; groups such as the National Council on Alcoholism make formal visits; staff physicians in the community hospitals where students do their clerkships speak up; individuls write to the deans.

"We learn to recognize whether an opinion is idiosyncratic or is one of substance and reflects a trend in health care," says W. Donald Weston, MD, dean of MSU's College of Human Medicine.

"But if we added all the requested courses without removing any, the curriculum would have to be extended an additional two terms," says Donald McBride, DO, Associate Dean for Academic Affairs in MSU's

Continued on page 212

Ms. Morningstar is a free-lance writer.

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MSMS leaders such as President James D. Fryfogle, MD, above, joined legislators such as Rep. Mary Keith Ballantine (R-Jackson) for the medical school deans' workshop. With them, center, is Geraldine M. Purcell, PhD, assistant dean, MSU College of Human Medicine, Flint campus.

College of Osteopathic Medicine.

Getting into and paying for medical school

How good are admission criteria — do they assure that the students who are going to be the best doctors are admitted?

The admissions personnel from all four schools feel there is a correlation between admissions criteria and producing good physicians.

"With maybe five percent of the students admitted, we find we've made a mistake," Doctor Weston says. "But 95 percent of our students do very well."

Henry Nadler, MD, dean of the Wayne State University Medical School, points out that with 3.2 applicants per available opening and with so many students meeting at least the minimal criteria, "you could fill a class four times and not be able to distinguish which were the first-choice applicants."

Does support for a medical school applicant by a legislator influence admission decisions?

"No, but if a legislator asks to take a closer look at a particular applicant, we'll extend that courtesy," Dean Magen says. "But it is the student's credentials and potential — not advocacy by a legislator — that will admit or reject the applicant."

Are medical schools admitting more blacks and other minorities?

Despite medical schools' efforts to recruit and admit more minority students, the proportion of minority physicians has grown very little in the past two decades.

"Virtually all of the qualified minority students are accepted into medical school, but we simply cannot achieve our minority enrollment objective without enlarging the pool of qualified applicants," says Charles Whitten, MD, Associate Dean for Curriculum Affairs, Wayne State University School of Medicine.

"We have to reach more minority students earlier. Too many youths have the intellectual ability for medical school but have inadequate academic backgrounds, have no role models to make a career in medicine seem possible, and no counseling to encourage them to pursue such a career. We have to improve counseling at the high school level, and at the college level we need to offer academic assistance."

At Wayne State University, disadvantaged students aspiring to medical school who cannot meet admissions criteria are offered a one-year remedial program to bring them up to standards in the basic sciences and in study skills. If they satisfactorily complete the remedial program, they are guaranteed admission to medical school.

Is the financial crunch going to mean that only the wealthy can afford to become physicians?

"Until now, financial difficulties have not prevented students from entering or completing medical school," says Sanford Cohen, MD, Associate Dean, Wayne State University School of Medicine. "But unfortunately that program is imminent."

At all four of Michigan's medical schools, between 85 to 90 percent of medical students receive financial aid. But financial assistance through such programs as the National Health Service Corps, Guaranteed Student Loans, and the National Student Health Loan is drying up. As a result, the mix of students admitted to medical school is going to be influenced by students' ability to finance their education and come up with living expenses while in school.

"No one will be denied admission because of inability to pay," Dean Nadler says. "But students who cannot afford medical school simply won't apply."

Doctor Nadler pointed out that a majority of graduating medical students are heavily in debt, owing between $16-40,000. "It would not be surprising," he says, 'to see a student graduate with a $60,000 debt in a few years. Already heavily indebted students will be asked to bear a greater financial burden."

Doctor Herrmann notes "as the state cuts back on general funds for medical schools, students will be asked to finance a greater share of their education."

Deciding where to practice

Can medical schools' curricula or admissions policies give incentive for graduating physicians to practice in specialties or geographic areas that are underserved?

"The admissions process is too early for trying to pin down a future physician's specialty choice," says Margaret Hunter, MD, Assistant Dean of Admissions at the University of Michigan Medical School. "Even if a medical school applicant is quite sure of where he or she wants to practice, we know that the student is going to change his or her mind during the clinical clerkship, when experience gives more information about what a

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October 15-16
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particular specialty involves."

"A lot of students at the end of their third year in medical school still don't know what they ultimately wish to do," Dean Nadler says. "It would yield very little to ask for a decision earlier."

As for where a physician practices, MSU's program to recruit Upper Peninsula natives and train them in the UP has led more graduating physicians to remain in the UP to practice.

"But economics are what will ultimately do the job of channeling doctors into underserved areas," Doctor Whitten says. "So many doctors are crowding into practice in the suburbs and so many desirable hospitals are at full capacity of admitting physicians, that it's becoming more profitable for a doctor to choose the less desirable, underserved locations."

The choice of the medical school itself has considerable bearing on ultimate practice decisions. Students applying at MSU, for example, are aware from the start that the school emphasizes general practice. Also, MSU's use of community hospitals rather than a campus-based university hospital may have some bearing on the type of community and hospital the student learns to prefer. A doctor learns how to be a doctor in a particular type of hospital, and that influences his or her later choice of practice.

Where the student does graduate work is also significant: 70 percent go into practice near where they attended graduate school. Current trends, such as the increase in the family practice specialty — have some influence on practice choice, as does the student's individual personality. "The surgical personality, for example, really does seem to be inborn," explains Roland Hiss, MD, coordinator of Affiliated Hospitals, University of Michigan Medical School.

Funding for medical schools

When the legislature is deliberating over budget decisions, can Michigan's four medical schools, each with a distinctive mission, speak with one voice regarding priorities?

"The four medical schools can probably speak with consensus more easily than could the three universities they're affiliated with," Dean Weston says. "This afternoon's workshop was an opportunity for the medical schools to discuss with legislators our shared concerns, without the pressure of pending budget decisions. I think it became clear that despite our differing orientations, we have common missions."

How severe an impact do state funding cutbacks have on the various medical schools?

The mix of revenues differs considerably from school to school, depending on the degree to which research is emphasized, the proportion of revenue generated from patient care, whether the school has its own university hospital or uses community hospitals, the extent to which practicing physicians are used as faculty, and so forth.

"But even at schools where state funding is a smaller portion of the total budget, it is the critical foundation on which other funding is based," says Thomas Herrmann, MD, Associate Dean, University of Michigan Medical School. "State investment allows us to attract other sponsored support."

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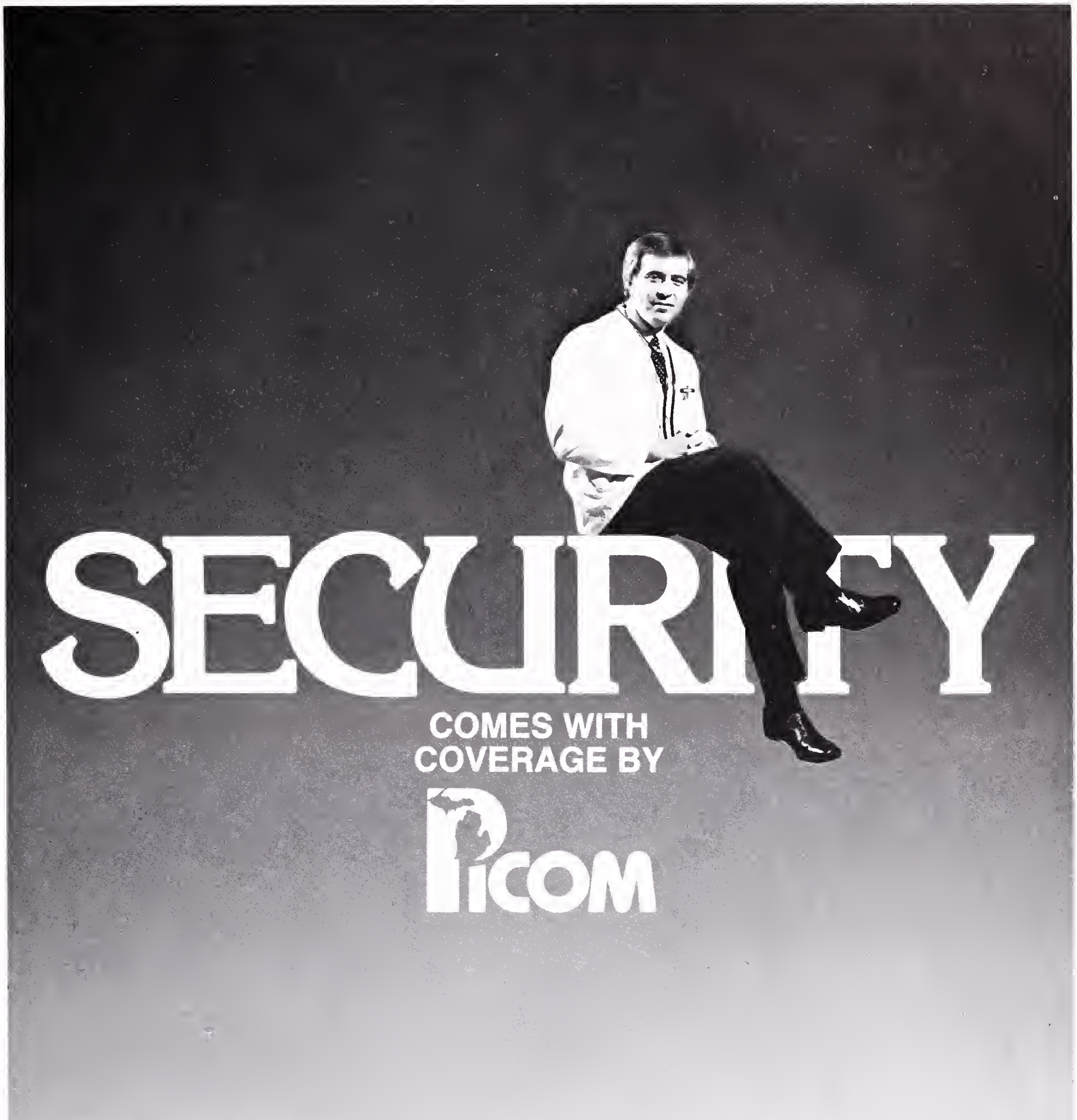

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: April 20-24, Spring Family Practice Review: Clinical Update. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Office of Continuing Medical Education, The University of Michigan Medical School. **Cost:** $395. **Contact:** Wendy L. Frisch, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 35.5 hours of Category I Credit.

Date: April 22-23, Eleventh Annual Critical Care Symposium. Location: Michigan Inn, Southfield. **Sponsor:** Wayne State University, Department of Surgery. **Contact:** Theresa Sokol, (313) 577-5009. **Approved for: 12 hours of Category I Credit.**

Date: April 24, The Medical Consequences of Nuclear Weapons and Nuclear War. Location: Music Hall Theatre, Detroit. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Contact:** WSU Division of Continuing Medical Education, University Health Center, 9B32, Detroit 48201 (313) 577-1180. **Approved for:** 5 hours of Category I Credit.

Date: April 23-25, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: April 25-29, Midwest Conference on Alcohol and Drug Abuse. Location: Valley Plaza, Midland. **Sponsor:** Bay Medical Education. **For:** All interested physicians. **Cost:** $225. **Contact:** James R. Tarrant, Director of Medical Education, Bay Medical Education, 615 Ninth St., Bay City 48706, (517) 892-1501. **Approved for:** 19 hours of Category I Credit.

Date: April 26-27, Modern Approaches to Eye Plastic and Orbital Surgery. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $255. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, University of Michigan, Ann Arbor 48109 (313) 764-2287. **Approved for:** 14 hours of Category I Credit.

Date: April 26-30, Advanced Muscle Energy Tutorial (Below Diaphragm). Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

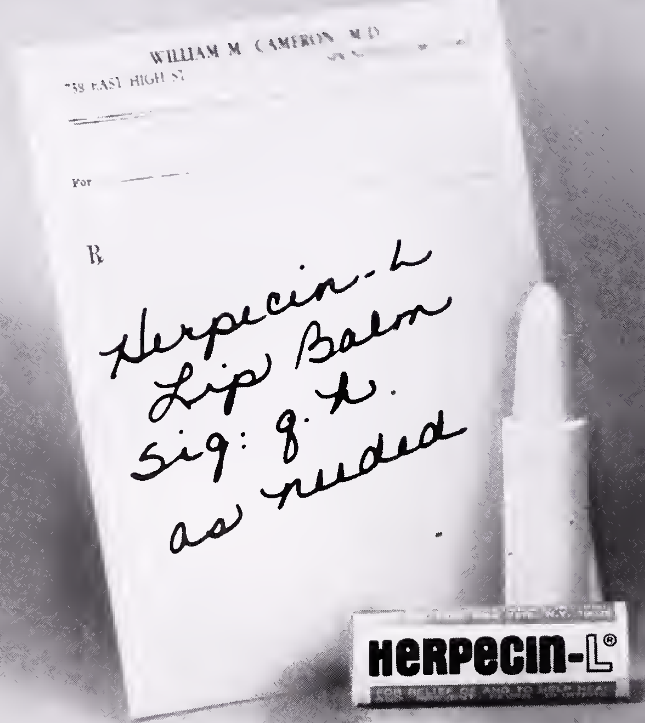
Date: April 27, Newer Developments in Infectious Diseases. Location: East Auditorium, Butterworth Hospital, Grand Rapids. **Sponsor:** Butterworth Hospital Medical Education Office. **Cost:** $40. **Contact:** Butterworth Hospital Medical Education Office, 100 Michigan, NE, Grand Rapids, MI 49503, (616) 774-1835. **Approved for:** 8 hours of Category I Credit.

Date: May 5, Wayne State University Medical Alumni Association Reunion and Clinic Day Topic: New Horizons in Medicine. Location: Michigan Inn, Southfield. **Sponsor:** Wayne State University Medical Alumni Association. **For:** Wayne State University Medical Alumni. **Contact:** WSU Medical Alumni Association, 540 E. Canfield, Detroit 48201, Room 1132, (313) 577-1495. **Approved for:** 5 hours of Category I Credit.

Date: May 6, 7, 8, Management of Coronary Artery Disease. Location: Westin Hotel, Detroit. **Sponsors:** Michigan Heart Association and American Heart Association. **Contact:** Eleanor D. Peterson, RN, Program Consultant, Michigan Heart Association, 16310 W. 12 Mile Road, PO Box 160-LV, Lathrup Village, 48076 (313) 557-9500. **Approved for:** 17 hours of Category I Credit.

Date: May 7-8, Nuclear Radiology Workshop with Minisymposia in Cardiopulmonary Nu-

Dx: recurrent herpes labialis



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clear Medicine and Updates in General Nuclear Medicine. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Office of Continuing Medical Education, The University of Michigan Medical School. **Cost:** $195. **Contact:** Wendy L. Frisch, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109 (313) 764-2287. **Approved for:** 15 hours of Category I Credit.

Date: May 12-13, "Perinatology: Transitions, Trends and Tragedies." Location: Kalamazoo. **Sponsor:** Bronson Methodist Hospital. **For (specialty):** all interested physicians. **Contact:** Valerie Lincoln, RN, Perinatal Coordinator, Bronson Medthodist Hospital, 252 E. Lovell, Kalamazoo 49006. **Approved for:** 5 hours of Category I Credit for each day's attendance.

Date: May 13-15, Medicolegal Investigation of Death. Location: Gordon Scott Hall, Detroit Medical Center. **Sponsors:** Wayne State University School of Medicine, Department of Pathology; Office of the Medical Examiner of Wayne County, and the Michigan Medical-Legal Research and Educational Association, Inc. **For:** Medical examiners, pathologists, coroners. **Contact:** Gerald Prieur, Division of Continuing Medical Education, WSU School of Medicine (313) 577-1180. **Approved for:** 15.5 hours of Category I Credit.

Date: May 14-16, May Seminar, Michigan Society of Pathologists. Location: Bay Valley Inn, Bay City. **Contact:** Willys Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint (313) 766-0134. **Approved for:** 3 hours of Category I Credit.

Date: May 15-16, "Lymphoma and Leukemia" and "Soft Tissue Tumors & Tumor-like Conditions." Location: Bay Valley Inn, Bay City. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** Willys F. Mueller, Jr., MD, Department of Pathology, Hurley Medical Center, One Hurley Plaza, Flint 48502 (313) 766-0134. Each of the two programs is **Approved for:** 3 hours of Category I Credit.

Date: May 17-21, Advances in Internal Medicine. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Office of Continuing Medical Education, The University of Michigan Medical School. **Cost:** $425. **Contact:** Wendy L. Frisch, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109 (313) 764-2287. **Approved for:** 35 hours of Category I Credit.

May 17-21, Advances in Internal Medicine. Location: Towsley Center for continuing Medical Education, University of Michigan. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **Cost:** $425. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 33.5 hours of Category I Credit.

Date: June 2-4, Current Topics in Blood Banking. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Office of Continuing Medical Education and Health Professions Education, University of Michigan. **Cost:** 175. **Contact:** Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 9 hours of Category I Credit. An additional 3-4 credit hours are available for participation in selected Preconference Workshops June 2.

Date: June 3 and 4, Prevention of Hereditary Large Bowel Cancer. Location: Westin Hotel, Detroit. **Sponsors:** Comprehensive Cancer Center of Metropolitan Detroit, Michigan Cancer Foundation, American Cancer Society, and National Large Bowel Cancer Project. **Cost:** $150. **Contact:** Elizabeth R. Holben, Michigan Cancer Foundation, 110 E. Warren Avenue, Detroit, 48201 (313) 833-1710. **Approved for:** 10 hours of Category I Credit.

Date: June 9, Medical Update in Family Practice, "The Geriatric Patient". Location: Saint John Hospital, Detroit. **Sponsor:** Continuing Medical Education Committee of Saint John Hospital. **For (specialty):** all interested Family Physicians. **Contact:** Linda Campbell (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 7-11, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit Receiving Hospital, 4201 St. Antoine in the Detroit Medical Center. **Sponsors:** Wayne State University School of Medicine Section of Emergency Medicine and American College of Emergency Physicians. **For:** Emergency medicine specialists. **Contact:** Gerald Prieur, Division of Continuing Medical Education, WSU School of Medicine (313) 577-1180. **Approved for:** 35 hours of Category I Credit.

Date: June 14-18, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine, and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-

Continued on page 218

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CATEGORY I/Continued

COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 18-20, 33rd Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University Department of Surgery. **Contact:** B. E. Henig, MD, Keyport Clinic, P.O. Box 605, Grayling 49738 (517) 348-6611. **Approved for:** 12 hours of Category I Credit.

Date: July 7-8, Wayne State University Symposium on Cerebral Resuscitation. Location: Westin Hotel, Detroit. **Sponsor:** Wayne State University School of Medicine. **Contact:** Gerald Prieur, Division of Continuing Medical Education, (313) 577-1180. **Approved for:** 12 hours of Category I Credit.

Date: July 22-25, Fourteenth Annual Summer Conference — Update for General Practice Ophthalmologists. Location: Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Cost:** $150. **Contact:** Leslie E. Meissner, MOS Administrative Assistant, (313) 839-3011. **Approved for:** 8 hours of Category I Credit.

Date: July 22-26, Intermediate Course on Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: July 29-30, Sixty-Second Annual Coller Penberthy Thirlby Medical Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center Continuing Education. **Cost:** $50. **Contact:** Norman Powers, Coordinator of Medical Education, Munson Medical Center, Traverse City 49684 (616) 947-6140, Ext. 146. **Approved for:** 9 hours of Category I Credit.

Date: July 30-Aug. 1, Arrhythmias and Cardiac Ischemia: Diagnosis and Management. Location: Boyne Mountain Resort, Boyne City. **Sponsor:** International Medical Education Corporation. **For:** Physicians, nurses and technicians. **Cost:** Physicians — $245, Nurses and technicians — $130. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, 64 Inverness Drive East, Englewood, CO 80112 (303) 773-1144 or 800-525-8646. **Approved for:** 13 hours of Category I Credit.

Date: Aug. 23-27, Tutorial on Direct Action Thrusting. Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: September 10-12, Fifth Annual Court in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Department of Radiology and Department of Postgraduate Medicine and Health Professions Education, The University of Michigan Medical School. **For:** all interested physicians. **Cost:** $275. **Contact:** David Bruce Youel, MD, Director, Office of Continuing Medical Education, Towsley Center, U-M Medical Center, Ann Arbor 48109 (313) 763-1423. **Approved for:** 16 hours of Category I Credit.

Date: Oct. 14-17, Annual Regional Meeting of the Michigan Chapter, American College of Physicians. Location: Traverse City Hilton. **Sponsor:** American College of Physicians, in association with the Michigan Society of Internal Medicine. **Contact:** Arnold R. Axelrod, MD, Sinai Hospital of Detroit, (313) 493-5780. **Approved for:** 25 hours of Category I Credit.

Date: October 15-16, Cardiac Rehabilitation. Location: Hyatt Regency Dearborn. **Sponsor:** International Medical Education Corporation. **Cost:** $245. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive East, Englewood, CO 80112 800-525-8651 or 303-740-8445, ext. 123. **Approved for:** 13 hours of Category I Credit.

Date: Oct. 25-29, Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of category I Credit.

Date: Nov. 1-5, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Nov. 8-10. Manual Medicine to the Extremities. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

NEWS/Continued

es, MD, Grosse Pointe, president-elect. . . . **Z. Emerick Szilagyi, MD,** Detroit, was awarded the Matas Memorial Lectureship by the 15th World Congress of the International Cardiovascular Society. The lectureship is awarded every two years to an American vascular surgeon and recognizes contributions to the advancement of the field. . . . **R.P. Warrier, MD,** Detroit, is a new member of the medical advisory board of the Children's Leukemia Foundation of Michigan. . . . **Michael C. Tomlanovich, MD,** Detroit, has been elected to the board of directors of the American College of Emergency Physicians. . . . Detroit physician **Richard M. Nowak, MD,** has been appointed to the Council of Academic Societies of the American Association of Medical Colleges. . . . **Anne B. Young, PhD, MD,** Ann Arbor, has received a $100,000, three-year grant to study three diseases that cause death of brain tissue and loss of memory. Doctor Young, assistant professor of neurology at the University of Michigan Medical School, was one of 14 neuroscientists awarded a grant by the McKnight Foundation of Minneapolis. . . . Kent County Medical Society presented its 1982 Distinguished Service Award to **John R. Wilson, MD,** Grand Rapids. The award recognizes meritorious service to the community and the medical profession. . . . 1982 Officers of the Physicians of India Association are **Ujamlal Kothari, MD,** Bloomfield Hills, president; and **Bhimsen Rao, MD,** Bloomfield Hills, president-elect. . . . **Dorin L. Hinerman, MD,** Professor of Pathology at the University of Michigan, is new Chairman of the Michigan Cancer Foundation Board of Trustees. Doctor Hinerman has been an MCF Trustee since 1960. . . . **Gordon J. Prout, MD,** Saline, was honored recently by the community's hospital for his care, service and leadership over his 40-year hospital affiliation. A plaque embossed with his likeness will be mounted in the hospital's main lobby. . . . **Raymond C. Mellinger, MD,** Grosse Pointe Park, head of the Division of Endocrinology at Henry Ford Hospital, has been appointed the new editor of the *HFH Medical Journal*. . . . **Stanley R. Nelson,** executive vice president of Henry Ford Hospital, was named chairman of the Board of Trustees of the American Hospital Association in ceremonies held in Washington, DC recently. . . . **Alfred B. Swanson, MD,** Grand Rapids, is recipient of the American Academy of Orthopaedic Surgeons' Kappa Delta Award for his long term research work on flexible (silicone) implant arthroplasty. . . . **Kenneth Pierce, MD,** Dowagiac, received Rotary International's highest award recently. He was named a Paul Harris fellow. Doctor Pierce joined the Dowagiac Rotary Club in 1933 and served as president in 1937. . . . The late **John Wesley Moore, MD,** and his late wife, **Mabel Pelham Moore,** were the subjects of a recent article in the *Flint Journal* recognizing influential black citizens of that community in honor of Black History Month. Doctor Moore, who died in 1946 at the age of 54, was the first known black physician to practice in Flint, starting around 1918. . . . The Upjohn Company has promoted **Carter D. Brooks, MD,** to Distinguished Clinical Investigator, the highest position on the company's career path for clinical research physicians.

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MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

April 30-May 1-2 — MSMS House of Delegates, Westin Hotel, Renaissance Center, Detroit, contact: Richard Campau, MSMS headquarters.

May 3-5 — 56th Annual Convention MSMS Auxiliary, Grand Plaza, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

May 6 — MSMS Women Physicians Conference: How to Use "the System," Michigan Inn, Southfield, contact: Vada Davis, MSMS headquarters.

June 13-17 — Annual Meeting, American Medical Association, Chicago, contact: AMA, 535 N. Dearborn, Chicago 60610 (312/751-6000).

June 13-16 — AMAA Convention, Drake Hotel, Chicago, contact: Caroline Rich, MSMS headquarters.

June 30 — MSMS/INTRAV Rhine River Adventure (14 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

July 11-14 — The Council Midsummer Session, Grand Traverse Hilton, contact: Warren F. Tryloff, MSMS headquarters, 517/337-1351.

July 18 — MSMS/INTRAV Alpine Adventure (15 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

Oct. 28 — MSMS Leadership/Public Affairs Conference, Long's Convention Center, Lansing, contact: Bill Madigan or Kevin Kelly at MSMS headquarters.

Nov. 9-10-11 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Other meetings

April 15-16 — Nursing Standards Seminar, Grand Rapids, contact: Julie Efaw, Joint Commission for the Accreditation of Hospitals Headquarters.

April 24-25 — Stress Management Conference, sponsored by Seminars for Effective, Extended Knowledge, Book Cadillac Hotel, Detroit, contact: Dee Chrisler (313/238-1196).

May 5 — Childrens Hospital of Michigan William Evans Memorial Lecture "Psycho-social, Ethical and Legal Issues in Genetic Medicine," Detroit, contact CHM Community Relations, (313/494-5373).

May 5-6 — Childrens Hospital of Michigan Annual Clinic Days, "Disorders of Genetic Origin," Detroit, contact, CHM Community Relations (313/494-5373).

May 5-7 — Annual Meeting and Scientific Session, Michigan Chapter, American College of Surgeons, Grand Plaza Hotel, Grand Rapids, contact: Viola Heins, 517/337-1351.

May 7 — Annual Meeting of the Michigan Society of Thoracic Surgeons, Amway Convention Center, Grand Rapids, contact: Rodman E. Taber, MD, Secretary, Michigan Society of Thoracic Surgeons, Wayne County Medical Society, 1010 Antietam, Detroit 48207.

May 17 — Orthopaedic Clinic Day, Childrens Hospital of Michigan, Detroit, contact CHM Community Relations (313/494-5373).

May 20-22 — Michigan Association of Osteopathic Physicians and Surgeons, 83rd Postgraduate Conference and Scientific Seminar, Westin Hotel, Detroit, contact: D.A. Deshaw, Executive Director, Michigan Association of Osteopathic Physicians and Surgeons, 33100 Freedom Road, Farmington 48024, 313/426-2300.

June 1-3 — "A Look at Local Public Health in Michigan," Michigan Public Health Association, contact: MPHA, 1407 S. Harrison Road, Suite 340, East Lansing 48823.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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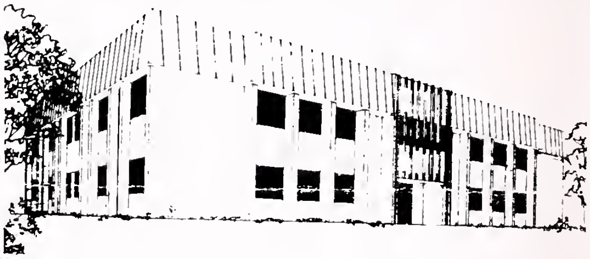

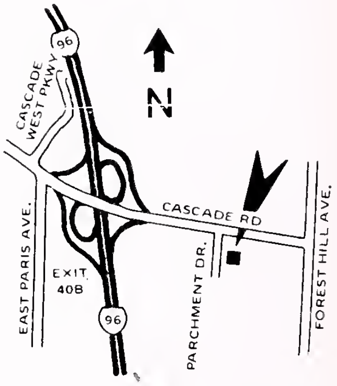

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"Staffing the professional office" Critical key to success

The recruitment, motivation and management of employees is viewed by many physicians as, at best, a necessary evil and, at worst, a task comparable to cleaning the Augean stables.

Too bad! These physicians are mishandling a responsibility that can have an immense influence — for good or ill — on the success of their practice.

Maintaining a skilled, productive and happy office staff can make your professional life a pleasant and profitable enterprise. But, as is usually the case, you must make an investment of time in learning the rudiments if you want to realize the dividends.

There are several steps that — if followed — will enable you to develop a staff that can maximize your effectiveness and improve your profit potential. These steps are: Needs Determination; Recruitment; Orientation; Training; Evaluation and Compensation; Motivation; Promotion and Termination.

NEEDS DETERMINATION — In these days of growing public impatience with the cost of health care and the increasingly competitive environment of medicine, it is important — if not vital — to staff your medical practice on the basis of need rather than tradition. No longer is it valid to staff your office solely on the basis of patterns established generations ago. How then, you may ask?

Begin with a needs assessment, which is a useful exercise even for the established practice. Take a notepad and — from your patients' perspective — list the functions that they might expect to be performed by you and your staff. Next, make another list of functions that are required by law, government agencies, professional standards, and other influential sources.

Indicate next to each function the manner in which the responsibility is to be met. Try to avoid determinations that are based only on traditional methods of handling such tasks.

Once you have completed the needs assessment, you can prepare a series of goals statements. As an example, you may have a goals statement that says:

> "All incoming telephone calls will be answered before the third ring and a disposition of the call will be made without requiring the caller to wait more than one minute and without having to call again."

Clearly, such a goal, based on patient need and good office practice, will require an effective call reception and processing system. This, in turn, will translate into a position description for a receptionist. The key is to develop clearly defined responsibilities and performance standards for the person who is hired as receptionist. This same process can be used for every function performed in your practice. Yes, that includes physician functions. It will be an interesting exercise to write a position description for your own functions. It will prove valuable when the time comes to expand your practice by taking a partner or hiring another physician for your group.

RECRUITMENT — It has been often and truly stated that most problems with staff members are rooted in the selection process. Another commonly heard statement is that mistakes are the reasons why pencils have erasers. The physician who accepts this latter statement as a rationale for capricious hiring practices is heading for a very painful experience.

When recruiting and selecting your staff, keep in mind a paraphrase of an old adage, "hire in haste, repent at leisure." Better to suffer the discomfiture of using temporary help during the recruiting process than to suffer the agony of dismissing an inept employee hired in a "crunch" situation.

The first step in hiring is to know the kind of person you are looking for and to have a written position description. This enables you to describe your needs to employment agencies, colleges and professional schools. An important resource that is sometimes overlooked is your current staff. Post the position description and ask your staff to recommend persons they know who might fit the requirements. Remember too, that promotion from within is an excellent way to solve an employment need.

It is probably unnecessary to mention it, but many upper level staff positions are filled though outright piracy. This course is fraught with peril since it invites retaliation. Again, don't rush the process. Set high standards and search until you find the right person. Don't oversell the position in order to fill it; this only leads to dissatisfaction and turn-over which is a very costly method of staffing. Persons who know what is expected of them, are compensated fairly, and kept informed of their status will usually be longterm in their positions.

It may be necessary to have someone pre-screen applicants based on your criteria. A simple rating matrix, covering education, experience, key job skills and interpersonal attributes can make it easier to select the top candidates for personal interviews.

You may also want to use prepared psychological and skills-testing examinations that are available from a variety of sources. Remember that these tests have a "shelf life" and should be evaluated regularly for efficacy.

When you begin to conduct interviews, be sure to pattern them in order to provide the highest possible level of objectivity. One prepared form that is available is the McMurry Patterned Interview Form produced by Dartnell Corp. There are many questions concerning the validity of interviews but there is little question that in the confined environment of a physician's office, it is imperative to maintain a favorable "chemistry" among co-workers. The interview provides the best opportunity to evaluate such factors and reduce the chance of hiring an incompatible staff member.

One final caveat. Make your decision as soon as possible, then let *all* applicants know their status. Your reputation as a professional will be enhanced by prompt, equitable treatment of all applicants.

ORIENTATION — An important — some say indispensable — part of the employment process is to have a well-planned orientation program. Too many physicians assume that because new staff members are experienced they do not require an orientation session. Everyone is ill-at-ease in a new environment and it takes more than a smile, hand-shake, and copy of the benefits booklet to accomplish an effective orientation.

Prepare a check-list of items to be covered with each new staff member and follow it. Include such minutiae as the location of the supply cabinet, after-hours phone numbers and how to operate the copying machine. Obviously, the physician is not expected to provide this information personally but it is important that the new staff member receives more than a perfunctory greeting.

Some of the items to be included in the orientation program should include:

- An office policies and procedures guide
- Assignment of a knowledgable person to serve as a counselor
- A description of the benefit package
- A brief description of the practice and its patients
- Travel reimbursement policies
- Office supplies and how to get them
- Accounting and payroll procedures
- Telephone and security procedures
- Correspondence style and policy
- Office idiosyncracies

You will have practices that are unique to your office but keep in mind that the first days of a new staff member are anxious ones for older staff as well. This anxiety can be disruptive of office productivity so every step you take to make the orientation painless will contribute to practice profitability.

TRAINING — By their nature, physicians' offices require well-trained staff. Some of this training will be conducted on the job. Such training is best accomplished through the use of Task Analysis Lists. Such lists can simplify and shorten the training period dramatically.

Breaking a task into its components can be done in many ways. Mager and Beach have defined five types of performance which may be required to complete a task: 1) Discrimination (determining between correct and incorrect processes); 2) Problem-solving (understanding causal and remedial relationships); 3) Recall (remembering an action or sequence of actions); 4) Manipulation (having the facility to perform a task physically); and 5) Speech (the level of oral skill needed to perform the task). By evaluating any task against these performance factors it is possible to develop an analysis of the training needed to prepare a person to perform it.

Well-trained staff members who understand and are properly motivated to accomplish their work can make all the difference to a medical practice.

Training methods are so diverse that they can not be adequately discussed here. But, it is essential that standards be set for the skills required and that staff be given the training to maintain those levels.

EVALUATION AND COMPENSATION — It is probably safe to say that few physicians' offices have formal evaluation and compensation plans. Too often, staff performance is evaluated under the pressure of complaints from patients or other physicians. Compensation is often based on subjective factors rather than any conscientious effort to determine appropriateness.

Staff members should be evaluated regularly against standards for job performance and for appropriate personality characteristics. This is usually best accomplished by using an appraisal form that measures such elements as knowledge of work; quantity and quality of work performed; initiative; attendance; and interpersonal skills. There are many such forms that can be purchased from business supply firms and used or modified to meet your needs.

Compensation is a delicate balance of many factors. The job market, cost of living, practice profitability, skills required, relative worth of the position within the organization, and other factors will influence the level of compensation for a particular position.

Whatever factors you use, be aware of one certainty, the salaries paid *will* become known to persons inside and outside your office. The best policy to follow is to establish levels for a position, review the levels annually, and stick to your plans even under threat and cajolery. Your practice is, after all, a business and should be run in a business-like manner. Nothing destroys office morale faster than the impression that some staff members are being favored over others.

If in doubt about salary levels, contact your area Chamber of Commerce, Department of Labor, other physicians and executives who employ comparable personnel. These contacts should enable you to fairly determine appropriate compensation levels. Be sure to assign a dollar value to your benefits package and consider this in your evaluations. A good employee is worth keeping, but *not* at any price.

MOTIVATION — High level job performance results from a complex variety of factors, not all of which can be controlled by the physician-manager. Recognition, remuneration, challenging work, advancement opportunities, security, and a plethora of other influences can and should be used to motivate higher levels of productivity.

Some staff members can be induced to produce through higher financial rewards but many studies have shown that this is not the major motivator for most. The problem for a physician-manager is to balance the motivational needs of each person without adversely affecting others.

The secret to operating a productive office is to provide incentives in a smorgasbord that will give each staff member those that are most important. It is also important to remove as many frustrations from the work environment as is possible.

Studies of the key elements in job satisfaction indicate that it has a direct relationship to productivity. These studies have also indicated that the most important elements in job satisfaction tend to be: 1) the nature of the work itself; 2) supervision; 3) the organization's reputation; 4) opportunities for advancement; 5) compensation; 6) co-workers; and 7) working environment.

This scale appears to favor physicians' offices as desirable places to work.

PROMOTION AND TERMINATION — The key factor here is to recognize that a physician's office is a relatively restricted environment for the person seeking advancement. Happily, not everyone is a zealous ladder-climber so there is a good chance to recruit and retain a fairly stable work force.

Even in the smallest office there is the opportunity for meaningful promotions if some basic rules are observed. Don't merely give the person a new title; broaden their responsibilities and authority. Be selective and objective in your promotions; beware of the Peter Principle and avoid advancing someone beyond the level of their capability.

Termination raises the spectre of a closed door session filled with vituperation and finger-pointing. The effective physician-manager knows how to avoid these unfortunate manifestations of involuntary termination.

The first rule is, "It must not come as a surprise." The way to observe this rule is review performance with the employee; set standards for expected improvement; set a time limit within which the improvement must be accomplished; and meet at an interval to discuss progress or the lack of it. Be specific about your disappointment if there is a lack of progress. A word of caution, don't send a message by trying to soften the situation with some sort of positive statement. This will confuse the person — are they making satisfactory progress or aren't they?

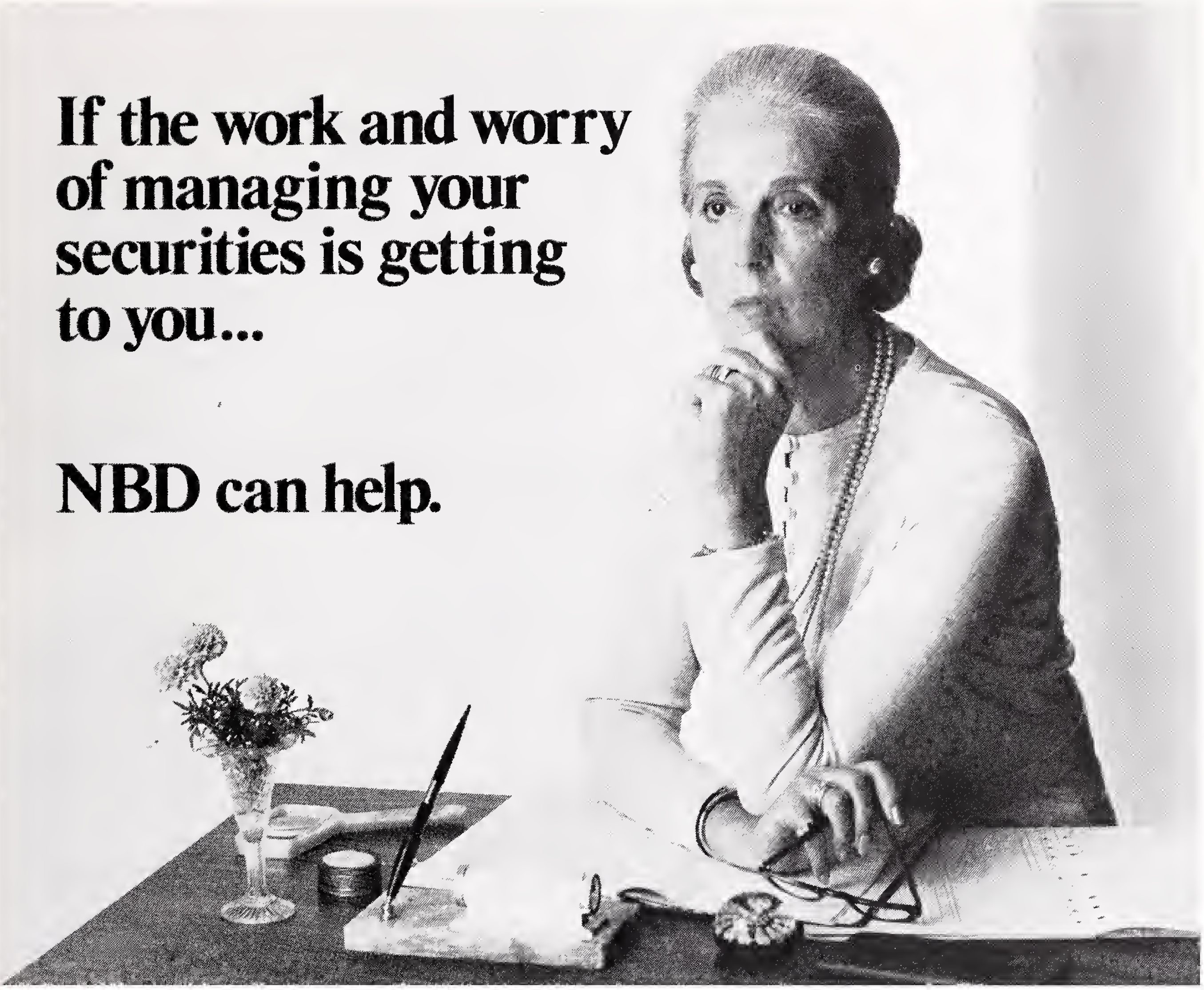
Another way to avoid "surprise" on the part of the terminated employee is to document your dissatisfaction and the improvements that are required. A memorandum with details should be given to the employee and placed in the file. If the goals are met, everyone should be pleased and go forward with enthusiasm. *Caution:* don't be tempted to remove memos and notes from an employee's file just because of progress; back-sliding has been known to happen.

If termination is decided upon, wait until the end of the work day and meet privately with the employee. Have a written dismissal notice and present it to the person for review and comment. Listen to any comments but be resolute in your decision. Use this opportunity to learn about possible symptoms of staff dissatisfaction. Make notes and place a memorandum in the file indicating matters that were discussed and key comments that were made. Be cool and professional.

When the employee terminates the relationship, try to schedule an exit interview. Much useful information comes from these usually candid discussions.

Recruiting, retaining and managing a productive office staff is critical to the success of your practice. Time spent learning and using the proper management techniques will pay long range benefits.

This article is excerpted from a larger section on practice management being prepared for the MSMS members' manual, "Meeting the Challenge of the 80s." The manual is the project of the MSMS Committee on Public Service, chaired by Robert D. Burton, MD, Grand Rapids. Excerpts will appear in Michigan Medicine *throughout 1982. They are designed to be removed easily and saved for reference.*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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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THE MULTIVITAMIN/MINERAL FORMULATION

MSU studies MDs' unease with patients unlike them

A commonly-held image of the doctor is that of the cool, detached, neutral professional who renders equal service to every patient.

However, a recently completed study by a Michigan State University social scientist indicates that doctors differentiate in their attitudes toward patients, and that patients whose characteristics or behavior differ from those of the doctor tend to elicit "negative reactions" from the doctor.

Further, says David Klein, study investigator, such patients are often those who most require good medical care.

Klein, professor of social science and adjunct professor of human development at MSU, conducted the study there, while one of his collaborators, Jackob Najman (senior lecturer at the University of Queensland Medical School in Brisbane) is conducting a similar, more detailed study in Australia.

Klein sent questionnaires to 1,000 current members of the Michigan Academy of Family Physicians, asking each to list five medical conditions and five social characteristics of patients which aroused feelings of "discomfort, reluctance or dislike."

Doctors' distaste

Of the 1,846 medical responses listed, the following appeared most often: "psychiatric conditions, mental illness" (56.7 percent); "alcoholism, drunkenness, alcohol abuse" (55.8 percent); "drug addiction, abuse, overdose" (42.1 percent); "obesity" (33.5 percent); "musculoskeletal pain, chronic back pain" (27.6 percent); "sexual behavior-related conditions, including unwanted pregnancies, excluding homosexuality" (26.2 percent).

Of 1,519 social characteristics listed, leading responses included "dirty, smelly, poor hygiene" (44.9 percent); "aggressive, angry, hostile" (26 percent); "noncompliant" (23.7 percent); "demanding" (20.7 percent); "Medicaid, welfare, workers' compensation patients and abusers" (19.8 percent).

Klein says some items were listed by some doctors as medical conditions and by others as social characteristics. Chief among these were alcoholism, homosexuality and obesity.

"These perceptions," he says, "are presumably related to the physician's opinion as to whether the causes of these conditions are biological or environmental."

Klein adds, however, that the listing by some physicians of such items as premarital (unwanted) pregnancy, child abuse, workers' compensation cases, and malingering as medical conditions shows that physicians "tend to perceive a wide array of phenomena through a 'medical window.'"

"That is, what to most people would appear as a social characteristic, appear to many physicians as a medical condition. Unwanted pregnancy, for example, is no different medically from pregnancy. The 'unwanted' aspect is purely social."

In another portion of the study, Klein categorized physicians' responses in an attempt to explain why physicians dislike certain kinds of patients.

Dislike helplessness

Of all medical conditions listed, the largest category (60 percent) represented conditions for which medical treatment offered little or no likelihood of cure or relief. These included cancer, severe mental or physical handicaps, chronic lung disease, senility, terminal diseases, psychiatric conditions, alcoholism, drug abuse and obesity.

"Doctors are trained to feel omnipotent," Klein points out. "The conditions they seem to dislike most are the ones they can't cure or aren't trained to cope with."

Of the social characteristics listed, the largest category (33 percent) involved behavior that violated the physician's personal standards, even though it had little or no bearing on the patient's health. Included were patients described as "dirty, smelly," "Medicaid, welfare, workers' compensation abusers," "malingerers," "chronically unemployed, lazy," "loud, rude, vulgar," "homosexuals," "spoiled brats," and "religious fanatics."

According to Klein, the responses indicate that American physicians as a group strongly adhere to the traditional American value system — the Protestant ethic — and that they tend to respond negatively to patients and illnesses which threaten or challenge their faith in that value system.

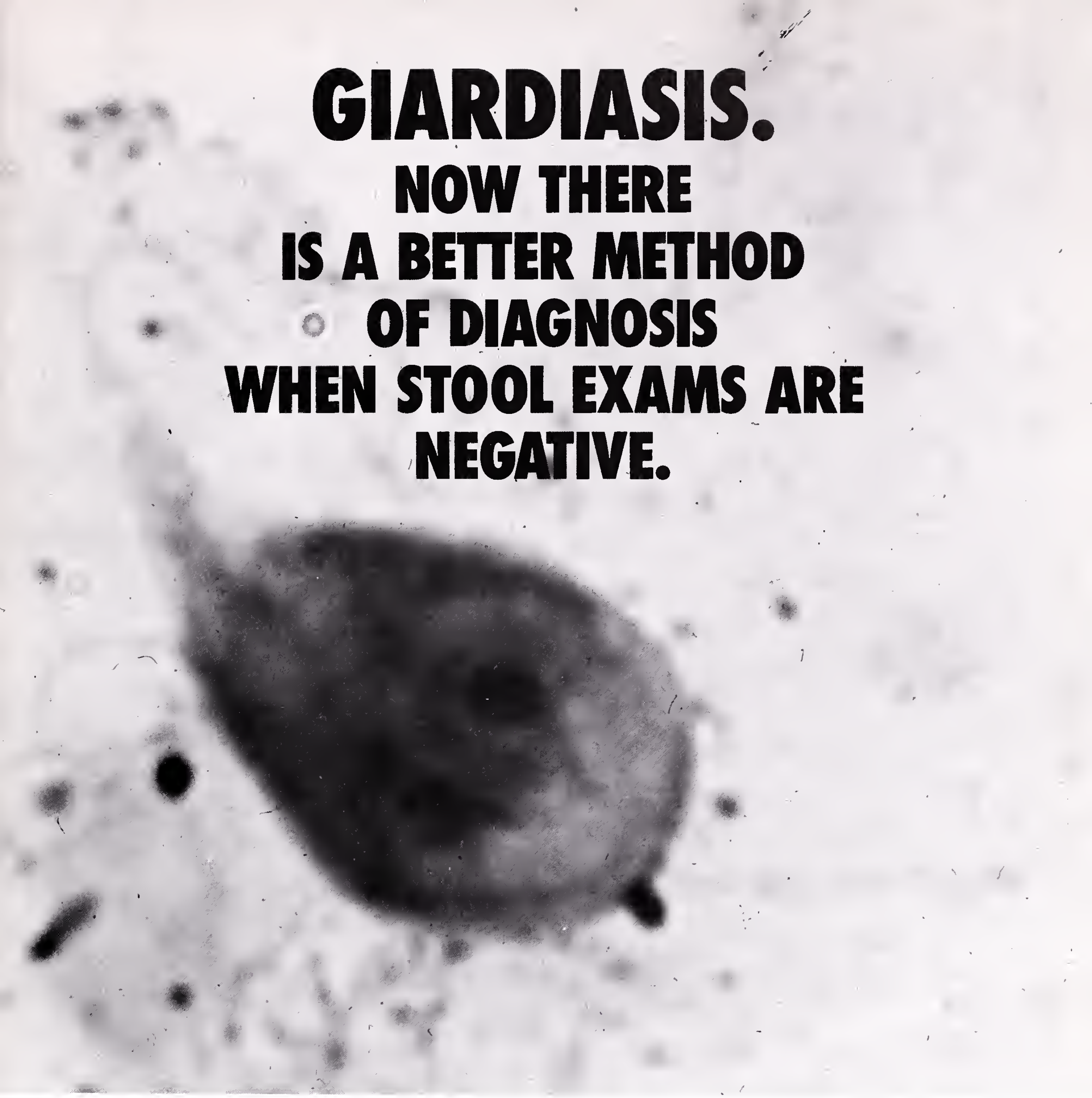
In discussing the results, Klein attributes the physicians' prejudices to the criteria by which they were selected to medical schools and the training they receive there. He believes changes are necessary.

"You can deal with this problem by changing the selection criteria or the medical curriculum or, better yet, you can change both."

Klein's study is scheduled for publication in the April 1982 issue of the *Journal of Family Practice.*

An update

On Oct. 22, Judge George LaPlata of the Oakland Circuit Court dissolved the summary suspension of George M. Shargel, MD, Madison Heights, which previously had been placed upon him by the Michigan Board of Medicine. The suspension was reported in the February issue of Michigan Medicine, as the editor had no notice of the Circuit Court's dissolvement. Any discomfiture to Doctor Shargel is deeply regretted.



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References:

Rosenthal, P., and Liebman, W.M: Comparative study of stool examinations, duodenal aspiration, and pediatric Entero-Test for giardiasis in children. *J. PEDIAT. 96:* 278 (Feb.) 1980.

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Topic — New treatments for Dementia
Morris Brown, M.D., Sinai Hospital, Wayne State University School of Medicine
Topic — Managing the critically ill patient

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Reception — 6 p.m.-7 p.m.

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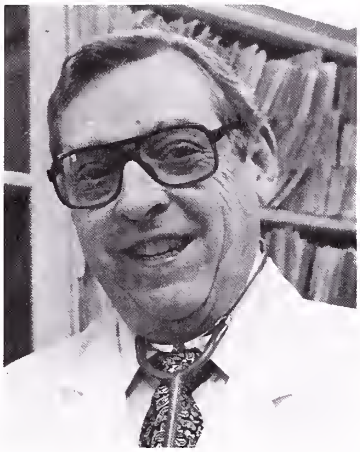


PRESIDENT'S PAGE

Looking forward to year of work and travel

By James H. Tisdel, MD
MSMS President-Elect

MSMS President James D. Fryfogle, MD, has given his column over this month to President-elect James H. Tisdel, MD, who will take office May 1 during the 1982 MSMS House of Delegates meeting in Detroit.

I am grateful to President Fryfogle for this opportunity to express some of my pre-inaugural thoughts in his regular President's Page space.

One of my primary wishes at this time is to recognize the work and efforts made by those like Doctor Fryfogle who have held this office before. I look forward greatly to a year of work and travel and to forwarding their programs already in progress.

I will make a conscientious effort during 1982-83 to visit as many component societies as time and work schedules will permit. We will continue with the current MSMS program to have component society presidents and officers become better acquainted with state headquarters, both officers and staff personnel.

Along those lines, I am most pleased with the plans for the coming MSMS workshop for hospital chiefs of staff. This event, scheduled March 25 at Long's Convention Center in Lansing, is a current portion of MSMS' intensifying effort to get back to our members with information from the state level.

I await with interest and pleasure Doctor Fryfogle's plan for an alternate method for health care financing. He has put in a year of hard work and overcome many obstacles in his effort to bring this new concept into place. It is nearing the point of its formal announcement to MSMS members and public and should provide a valuable option in our battle to control health care costs.

I also plan to borrow from John R. Ylvisaker, MD, MSMS president in 1980-81, who stressed professionalism and humanitarianism. Our new MSMS Committee on Humanitarian Service, which I chair, is at work now supporting and promoting carefully selected services offering care to those in need, such as World Medical Relief, and Project Health Care for the unemployed.

One of my primary activities will be to work for passage of new malpractice legislation as proposed by our MSMS Committee on State Legislation and Regulations. This legislation is being developed as a result of our Council's quick response to a recent Michigan Supreme Court decision. The Court ruled against a Michigan physician who attempted to countersue two lawyers for bringing a case which was decided in the physician's favor.

The legislation MSMS is proposing is to provide a long-term solution to minimize frivolous or malicious malpractice suits. It will ask for:

1) Structured or periodic scheduled payments for bodily injury cases;

2) Limitations on pain and suffering damages;

3) Mandatory screening panels;

4) Abandonment of joint and several liability for damages, and

5) Requirement of bond by plaintiff attorneys, recovery of cost and collateral source legislation.

Through my year in office I will remain mindful of the costs of medical care and the pressures causing their increase — inflation and government regulations — and will work to promote those things Michigan citizens can do themselves to control costs.

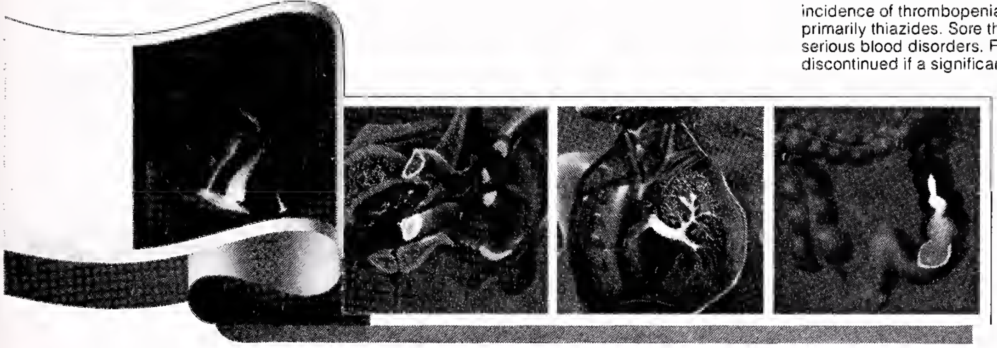
Among those things private citizens may do, of course, are to decrease smoking, alcohol consumption, drug abuse, automobile accidents, homicides and suicides. All of these destructive activities cost us billions of dollars of health care money.

Finally, and most importantly, I pledge to devote my time and abilities to represent MSMS, to maintain the highest level of trust and devotion to our membership.

Bactrim™ (trimethoprim and sulfamethoxazole) succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy



in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae.* To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopio examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1]...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1]... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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160 mg trimethoprim and 800 mg sulfamethoxazole
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* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

MICHIGAN MEDICINE

May 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 81, No. 24

DAVID SIEGEL, M.D.
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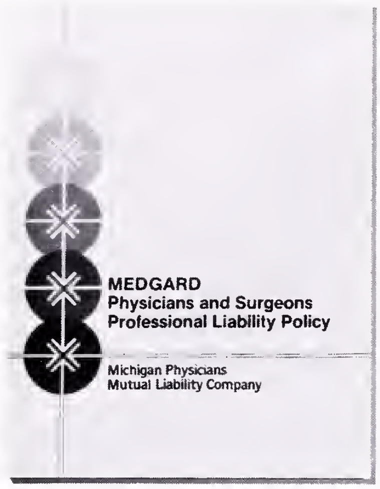

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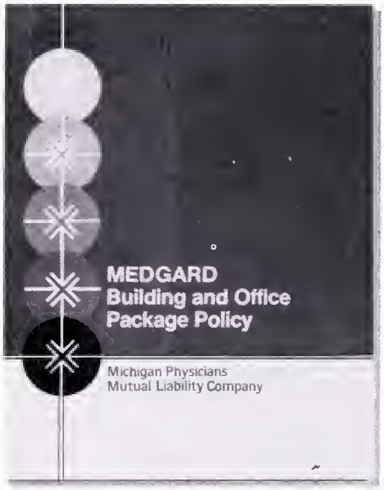

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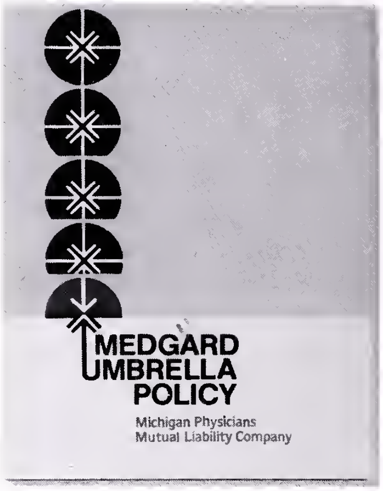

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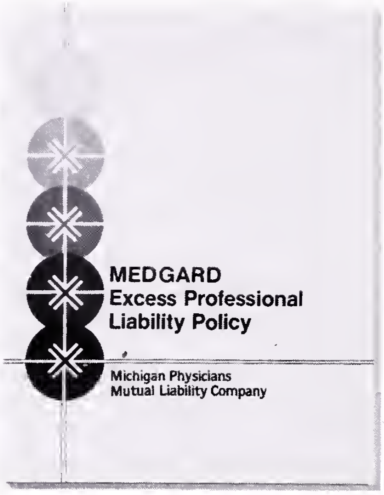

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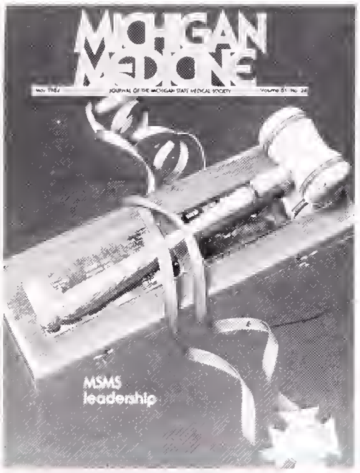

The symbols of MSMS leadership adorn this month's cover, to lead readers into the special report on the officers of the state society. Articles begin on page 242. **(Photo by Mert Scholten)**

MICHIGAN MEDICINE

May 1982, Volume 81, No. 24

Special report

242 MSMS leaders realize that attainment of a lofty leadership position often can have the unfortunate correlate of removal from the grassroots membership. To help remedy that situation, this issue presents profiles and feature stories on the current MSMS officers. It is hoped these articles will help MSMS members get to know their leaders better; Judith Marr

Features

253 Meeting the challenge of the 80s: Part III in the MSMS series

267 Up-to-date version of component society officers' list

270 Autobiography of an alcoholic medical student; from Ward M. Smathers, MD

274 New laws mandate Medicare changes

288 Cost containment training can reduce medical costs; Deborah Zannoth

302 Noted writer/economist Harry Schwartz, PhD, advises Kalamazoo Academy members they must compete as any other entrepreneur; Judith Marr

Departments

238 In my opinion; Harvey M. Andre, MD

239 Letters

258 MSMS/A; Barbara Grennan

260 News

262 Medicolegal; A. Stewart Kerr

272 Newsfronts

275 New members

280 Category I courses

287 Meetings

290 Deaths

300 Classified advertising

301 Ad index

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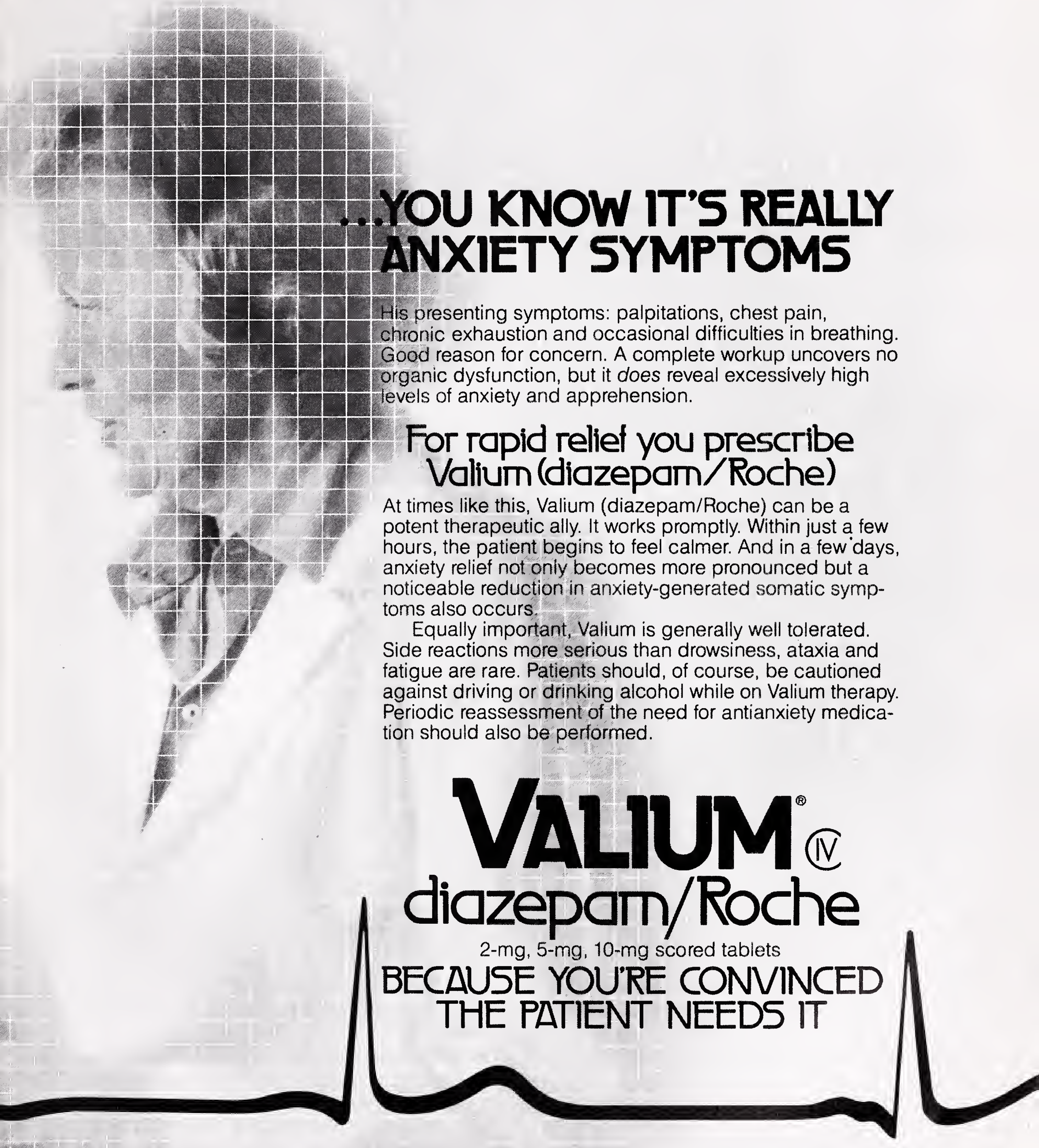
THE PATIENT THINKS HE HAS HEART TROUBLE...



...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

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2-mg, 5-mg, 10-mg scored tablets

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Please see summary of product information on the following page.

they are getting into and they are more willing to be active participants." (Doctor Tisdel was instrumental in establishing Port Huron Hospital's Expectant Parent Course in 1956.)

"We've progressed tremendously, especially in terms of maternal mortality. It is very rare for a mother to not survive childbirth."

The advent of specialized drugs and treatments has been the most monumental change in medicine, he observes, remembering that "penicillin was just becoming available when I was a medical student."

Since those early days of medical school, Doctor Tisdel has earned not only the respect of the community he serves, but also a high level of professional recognition. He is a diplomat of the American Board of Obstetrics and Gynecology, a fellow in both the Michigan and American Colleges of Obstetricians and Gynecologists, and an active member of the American Medical Association.

In recent years, Doctor Tisdel has become increasingly enamored by Arizona, especially Tucson. He now owns a townhouse in this area, which he first explored while based in Texas. He hopes someday to be able to spend more time visiting during Michigan's cold winter seasons.

"They say man made places like Florida, but Arizona was made by God. It's just so entirely different. I enjoy exploring the flora and fauna of the desert, on foot and through books."

Nearing his 60th birthday (born July 8, 1922 in Plymouth, Pennsylvania), Doctor James H. Tisdel reflects on a life he believes has been blessed in so many ways . . . by a good education, a wonderful wife and family, a community of natural beauty, quality people, and excellent hospital staff and facilities, four outstanding physicians who are his partners in Blue Water Obstetrics and Gynecology, PC, and a nucleus of dedicated office staff.

"Much of life depends on accidental circumstances, which we are unable to control. In my case, I'm thankful that those accidents have turned out to be blessed events."

Doctor Tisdel takes a coffee break with his dedicated office staff members.

Long-time friends Doctor Tisdel and Port Huron surgeon John J. Coury, MD, right, share a relaxed moment between cases. Doctor Coury is a former MSMS president and now is running for re-election to the AMA Board of Trustees.

With the assistance of Kit Nuss, LPN, Doctor Tisdel encourages an expectant mother awaiting delivery of her child.

Remember G.E. Frothingham? or Cyrenus G. Darling?

MSMS has been served over the years by the following presidents

1866 — C. M. Stockwell, M.D., Port Huron
1867 — J. H. Jerome, M.D., Saginaw
1868 — Wm. H. DeCamp, M.D., Grand Rapids
1869 — Richard Inglis, M.D., Detroit
1870 — I. H. Bartholomew, M.D., Lansing
1871 — H. O. Hitchcock, M.D., Kalamazoo
1872 — Alonzo B. Palmer, M.D., Ann Arbor
1873 — E. H. Jenk, M.D., Detroit
1874 — R. C. Kedzie, M.D., Lansing
1875 — Wm. Brodie, M.D., Detroit
1876 — Abram Sager, M.D., Ann Arbor
1877 — Foster Pratt, M.D., Kalamazoo
1878 — Ed Cox, M.D., Battle Creek
1879 — George K. Johnson, M.D., Grand Rapids
1880 — J. R. Thomas, M.D., Bay City
1881 — J. H. Jerome, M.D., Saginaw
1882 — Geo. W. Topping, M.D., DeWitt
1883 — A. F. Whelen, M.D., Hillsdale
1884 — Donald Maclean, M.D., Detroit
1885 — E. P. Christian, M.D., Wyandotte
1886 — Charles Shepard, M.D., Grand Rapids
1887 — T. A. McGraw, M.D., Detroit
1888 — S. S. French, M.D., Battle Creek
1889 — G. E. Frothingham, M.D., Detroit
1890 — L. W. Bliss, M.D., Saginaw
1891 — George E. Ranney, M.D., Lansing
1892 — Charles J. Lundy, M.D., Detroit
(Died before taking office)
Gilbert V. Chamberlain, M.D., Flint
(Acting President)
1893 — Eugene Boise, M.D., Grand Rapids
1894 — Henry O. Walker, M.D., Detroit
1895 — Victor C. Vaughan, M.D., Ann Arbor
1896 — Hugh McColl, M.D., Lapeer
1897 — Joseph B. Griswold, M.D., Grand Rapids
1898 — Ernest L. Shurly, M.D., Detroit
1899 — A. W. Alvord, M.D., Battle Creek
1900 — P. D. Patterson, M.D., Charlotte
1901 — Leartus Conner, M.D., Detroit
1902 — A. E. Bulson, M.D., Jackson
1903 — Wm. F. Breakey, M.D., Ann Arbor
1904 — B. D. Harison, M.D., Sault Ste. Marie
1905 — David Inglis, M.D., Detroit
1906 — Charles B. Stockwell, M.D., Port Huron
1907 — Herman Ostrander, M.D., Kalamazoo
1908 — A. F. Lawbaugh, M.D., Calumet
1909 — J. H. Carstens, M.D., Detroit
1910 — C. B. Burr, M.D., Flint
1911 — D. Emmet Welsh, M.D., Grand Rapids
1912 — Wm. H. Sawyer, M.D., Hillsdale
1913 — Guy L. Kiefer, M.D., Detroit
1914 — Reuben Peterson, M.D., Ann Arbor
1915 — A. W. Hornbogen, M.D., Marquette
1916 — Andrew Biddle, M.D., Detroit
1917 — Andrew P. Biddle, M.D., Detroit
1918 — Arthur M. Hume, M.D., Owosso
1919 — Charles H. Baker, M.D., Bay City
1920 — Angus McLean, M.D., Detroit
1921 — Wm. J. Kay, M.D., Lapeer
1922 — W. T. Dodge, M.D., Big Rapids
1923 — Guy L. Connor, M.D., Detroit
1924 — C. C. Clancy, M.D., Port Huron
1925 — Cyrenus G. Darling, M.D., Ann Arbor
1926 — J. B. Jackson, M.D., Kalamazoo
1927 — Herbert E. Randall, M.D., Flint
1928 — Louis J. Hirschman, M.D., Detroit
1929 — J. D. Brook, M.D., Grandville
1930 — Ray C. Stone, M.D., Battle Creek
1931 — Carl F. Moll, M.D., Flint
1932 — J. Milton Robb, M.D., Detroit
1933 — George LeFevre, M.D., Muskegon
1934 — R. R. Smith, M.D., Grand Rapids
1935 — Grover C. Penberthy, M.D., Detroit
1936 — Henry E. Perry, M.D., Newberry
1937 — Henry Cook, M.D., Flint
1938 — Henry A. Luce, M.D., Detroit
1939 — Burton R. Corbus, M.D., Grand Rapids
1940 — Paul R. Urmston, M.D., Bay City
1941 — Henry R. Carstens, M.D., Detroit
1942 — H. H. Cummings, M.D., Ann Arbor
1943 — C. R. Keyport, M.D., Grayling
1944 — A. S. Brunk, M.D., Detroit
1945 — V. M. Moore, M.D., Grand Rapids
(Died before taking office)
1945 — R. S. Morrish, M.D., Flint
1946 — Wm. A. Hyland, M.D., Grand Rapids
1947 — P. L. Ledwidge, M.D., Detroit
1948 — E. F. Sladek, M.D., Traverse City
1949 — Wilfred Haughey, M.D., Battle Creek
(President-for-a-day, Sept. 21, 1949)
1949 — W. E. Barstow, M.D., St. Louis
1950 — C. E. Umphrey, M.D., Detroit
1951 — Otto O. Beck, M.D., Troy
1952 — R. L. Novy, M.D., Detroit
(President-for-a-day, Sept. 22, 1952)
1952 — R. J. Hubbell, M.D., Suttons Bay
1953 — L. W. Hull, M.D., Brighton
1954 — L. Fernald Foster, M.D., Bay City
(President-for-a-day, Sept. 28, 1954)
1954 — R. H. Baker, M.D., Pontiac
1955 — W. S. Jones, M.D., Menominee
1956 — Arch Walls, M.D., Kalispell, Montana
1957 — G. W. Slagle, M.D., Battle Creek
1958 — G. B. Saltonstall, M.D., Charlevoix
1959 — Milton A. Darling, M.D., Detroit
1960 — Kenneth H. Johnson, M.D., Lansing
1961 — Otto K. Engelke, M.D., Ann Arbor
1962 — Clarence I. Owen, M.D., Jacksonville, Fla.
1963 — Orlen J. Johnson, M.D., Bay City
1964 — Oliver B. McGillicuddy, M.D., Lansing
1965 — Luther R. Leader, M.D., Royal Oak
1966 — C. Allen Payne, M.D., Grand Rapids
1967 — Bradley M. Harris, M.D., Ypsilanti
1968 — James J. Lightbody, M.D., Detroit
1969 — Robert J. Mason, M.D., Birmingham
1970 — Harold H. Hiscock, M.D., Flint
1971 — Sidney Adler, M.D., Detroit
1972 — John J. Coury, M.D., Port Huron
1973 — Brooker L. Masters, M.D., Fremont
1974 — Brooker L. Masters, M.D., Fremont
1975 — Brock E. Brush, M.D., Detroit
1976 — Robert M. Leitch, M.D., Battle Creek
1977 — Vernon V. Bass, M.D., Saginaw
1978 — Louis E. Heideman, M.D., Birmingham
1979 — Ernest P. Griffin, Jr., M.D., Flint
1980 — John R. Ylvisaker, M.D., Bloomfield Hills
1981 — James D. Fryfogle, M.D., Southfield
1982 — David Siegel, MD, Lansing
(President-for-a-day, May 1, 1982)

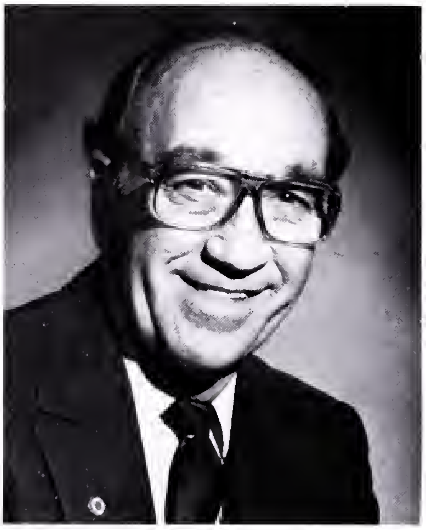
MSMS Leadership in Profile

MSMS President-elect

Donald K. Crandall, MD
Muskegon

Doctor Crandall serves as AMA delegation representative on the MSMS Council, where he also chairs the new Committee on Health Care Delivery. He has been an AMA delegate since 1977 and prior to that was alternate delegate two years. He is an MSMS appointee to the Blue Cross Blue Shield Corporate Body and to the Michigan Association of the Professions Board of Directors. He is a sustaining member of the Michigan Doctors and American Medical political action committees. He is a member of the Advisory Committee to the MSMS Bureau of Economics, and from 1972 to 1979 was chairman of the MSMS Negotiating Committee. He is past president of the Muskegon County Medical Society, is vice president of the Greater Muskegon HMO, and serves on the board of directors of the Michigan Society of General Surgeons. Doctor Crandall is a graduate of the University of Michigan Medical School. He and his wife, Nancy, have three sons.

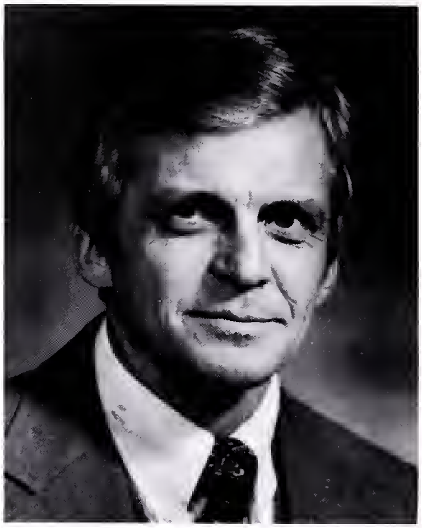
MSMS Immediate Past President



James D. Fryfogle, MD
Southfield

Doctor Fryfogle served as MSMS president from May, 1981-May, 1982, after serving as vice speaker and then speaker of the MSMS House of Delegates for a number of years. He also is past president of the Wayne County Medical Society and past member of the WCMS Council. He has served for years on the Comprehensive Health Planning Council of Southeast Michigan, and founded and serves as the chairman of the Seven County Physicians Health Planning Advisory Committee to CHPC-SEM. A graduate of Albion College and Wayne State University Medical School, Doctor Fryfogle is a thoracic surgeon who practices at Providence Hospital, Southfield, and Mt. Carmel Mercy Hospital. He is director of the W. D. Fryfogle Medical Research Laboratories, and a member of the American College of Chest Physicians and American Heart Association. He and his wife Evelyn are the parents of two daughters and one son. Doctor Fryfogle has been active with the Boy Scouts of America and the Society for the Preservation and Encouragement of Barbershop Quartet Singing in America.

MSMS Council Chairman



Thomas R. Berglund, MD
Portage

Doctor Berglund has served as MSMS Council Chairman for a year. He is past chairman of the Michigan Doctors Political Action Committee, and now serves on the board of the American Medical Political Action Committee. He is past president of the Kalamazoo Academy of Medicine and is affiliated with Bronson and Borgess hospitals there. He has practiced at the Portage Medical Clinic since 1961, and is a graduate of the University of Michigan Medical School. He is a board certified family physician and member of the American Academy of Family Physicians. He and his wife, Jill, have one son and one daughter.

Speaker MSMS House of Delegates

Gerald H. Mandell, MD
Southfield

Doctor Mandell is the newly-elected speaker of the MSMS House of Delegates, following a year of service as vice speaker. Doctor Mandell also is chairman of the MSMS Task Force on Medical Fraud and Abuse, and member of the MSMS Task Force on MSMS Structure, Medicaid Liaison Committee, Council Reference Committee on Health Care Delivery, and Ad Hoc Committee to Study Peer Review Structure. Doctor Mandell has been active with the Wayne County Medical Society, where he is a former councilor and trustee. He now serves on the WCMS editorial board, service bureau board and ethics committee. Doctor Mandell is an alternate delegate to the AMA. A pathologist, he is a fellow of the College of American Pathologists and American Society of Clinical Pathologists. He is a founding fellow of the American Society of Coagulationists, and is a member of the Michigan Association of Blood Banks. Doctor Mandell holds an MD degree from Wayne State University School of Medicine and is associate chairman of laboratories for Sinai Hospital of Detroit. He and his wife, Beatrice, have five children.

Council vice chairman

Doctor Gagliardi
Dearborn

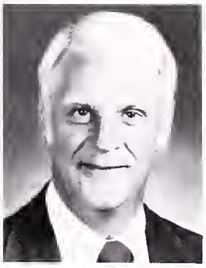
Carl Gagliardi, MD, a pediatrician, has been vice chairman of the MSMS Council for one year. Prior to that he served as a councilor from the First District for three years, and as an MSMS delegate for three years. He also served on the Michigan Doctors Political Action Committee board, and was an alternate delegate to the AMA. A graduate of Yale University School of Medicine, he is a past president of the Wayne County Medical Society, and has been chief of pediatrics for Oakwood and Outer Drive hospitals in the Detroit area.

Vice speaker MSMS House of Delegates

Doctor Burton
Grand Rapids

Robert Burton, MD, is newly-elected MSMS vice speaker, after serving as an MSMS delegate since 1974. He also is chairman of the MSMS Committee on Public Service, and serves on the MSMS committees on state legislation and regulations and member services. He is an AMA delegate and past president of the Kent County Medical Society. An otolaryngologist, he is a graduate of The University of Michigan Medical School.

Chairman, Michigan AMA Delegation



Doctor McMurray
Flint

Richard McMurray, MD, has been chairman of the Michigan Delegation to the AMA for two years and also serves as chairman of the MSMS Committee on Federal Legislation. He is a member of the MSMS Judicial Commission. He is past president of the Genesee County Medical Society. He is chief of obstetrics and gynecology at McLaren Hospital.

MSMS Secretary

Doctor Leitch
Battle Creek

Robert Leitch, MD, a Battle Creek family physician, is an MSMS past president (1976-77), and served as chairman of the MSMS Council for three years. Doctor Leitch also is a past president of the Branch County Medical Society, was an MSMS delegate and is currently President of MPMLC.

MSMS Treasurer

Doctor Holly
Muskegon

Leland Holly, II, MD, has served as MSMS treasurer for three years, and is a former assistant treasurer and Council Finance Committee chairman. He was a Councilor for six years, and was an incorporator of MPMLC. He is past secretary of the Muskegon County Medical Society, and former alternate delegate to the American College of Radiology.

An MSMS leader looks at his organization

By Judith Marr, Editor

Michigan Medicine **recently asked MSMS secretary Robert M. Leitch, MD, Battle Creek, for some honest and forthright opinions on the directions the medical society has taken in recent years and its necessary future headings. Doctor Leitch should know. He is a past MSMS president and former Council chairman, and has served years as an MSMS delegate. He was MSMS spokesman during the volatile medical malpractice insurance crisis of the 1970s.**

Q: What, in your opinion, does it take to be an MSMS officer?

A: I would say basically time and dedication. I feel that any physician who accepts an office in the medical society must be willing to devote the time necessary to doing a worthwhile job and the dedication to see the job through. It takes a person who gets along well with others, who communicates easily, and who is able to work with other physicians and staff in a harmonious and productive manner.

Q: What former MSMS leaders stand out in your mind, and why?

A: I would certainly consider Ken Johnson, who served many years in various capacities, including speaker of the house, MSMS president and long-time secretary, as one of our outstanding and dedicated leaders. Another former leader who comes to mind is George Slagle, who as a younger man served as MSMS president. For many years he represented Michigan well as a delegate to the American Medical Association. George served as chairman of the AMA Council on Medical Service, and finally was elected vice president of the AMA, a very singular honor. He always has been well-respected in AMA circles, and certainly is one of the better known Michigan physicians. Presently serving the medical society very well, is John Coury, the only member of MSMS who has ever been an AMA trustee. John did an outstanding job as councilor and president of MSMS as well as providing long years of service as an AMA delegate. In this group I must include Harold "Dutch" Meier, of Coldwater, who served as delegate from Branch County for many years, as councilor from the third councilor district, and during his later years as Council chairman. Dutch was a strong, fearless leader.

Q: What twists and turns have you observed in MSMS political and policy history?

A: It seems to me that one of the significant turns in the policy and political history of our organizationi occurred 25 years ago, when the Council took a stronger stand in the everyday affairs of medical society activity. Prior to that, the society was run pretty much by an executive committee and a strong executive staff. The council, at least by my perception, acceded to the desires and activities of this small group. Changes were made then to curtail its power and to distribute it over the entire Council. This, in my opinion, was definitely for the good. It seems to me that an association such as ours must have a fairly broad base of top-level input; otherwise, it tends to become dictatorial.

I think recent developments which have more actively involved the society in socioeconomics and politics are significant. I feel this also, is good. During the early years of the society there wasn't as much opportunity for excellent postgraduate education as now, and the society had to take a role in that area. Of course, we still have excellent scientific programs, including the Maternal Health Conference, the Conference on Sports Medicine and the MSMS Scientific Meeting.

The original Michigan Medical Service, later Blue Shield, and now amalgamated with Blue Cross to form Blue Cross/Blue Shield of Michigan, was spearheaded by MSMS in the late 1930s and early 1940s to help those who could not afford their own medical, particularly hospital, bills.

BCBSM's development from rather modest beginnings to a corporate giant is well known to all of us. The changes over the years in the relationship of MSMS to BCBSM also are well known, and some of them are not completely tasteful. The close relationship which we enjoyed in the early years gradually deteriorated to the point of animosity in many cases. In the early 1970s the complete "divorce" of the society and Blue Shield probably led to the activities which stimulated the FTC to bring antitrust charges against MSMS.

To me this has been an unpleasant aspect of our activity over the years. It has taken a great deal of our valuable time and money which could have been spent well elsewhere. Perhaps it has accomplished some improvement, but I do not consider it to have been cost-effective.

The changes in leadership at the staff level 10 to 15 years ago certainly have changed the face of our society considerably. The leadership seemed to spend a great deal of time on public relations activities, before that time, and while these activities are important, there are many other things to which we are dedicated today. I believe we have upgraded the quality of our society's activities.

Continued on page 250

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; J. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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DOCTOR LEITCH/*continued*

Q: Where is MSMS headed today?

A: I think we can only consider the society to be headed forward. We are growing. We recently accepted our 10,000th member. We must try to bring in all the segments of the medical profession and as many as possible of the ethical, reputable physicians in the state as we can. We must provide a voice for all physicians, and unless we are able to continue in this direction, we probably will find ourselves losing strength.

Q: What are some of the major issues you believe the medical society will confront?

A: We must confront the variety of methods by which medicine is practiced today, and we must support those which are in the best interests of our patients and our profession. As more competitive forms of medical practice develop, we must see that the competition is in the best interest of medicine in general, and speak out on the issues when we feel that this is not the case. We must continue to sponsor and foster the highest degree of medical ethics, and not allow our historical ethical posture to be diluted and weakened by outside selfish interests. We must face squarely the issue of the cost of medical care and do everything in our power to try to contain costs where cost containment is not a deterrent to good medical care. We must continue to improve our activities in the field of medical/professional liability, to decrease the risks of liability and to try to contain the escalating costs of liability insurance. These issues should be dealt with through legislative activity, active staff work, and a well-balanced committee structure.

Q: What type of leaders must MSMS have in the future?

A: I think it is incumbent upon our present membership and leadership to recruit the best and most incisive minds of the physician community for medical society leadership. It has been a feeling of mine at times that some of our best and potentially most promising leaders have failed to take an interest in the medical society's activities, with the result that some of our work may not be of the quality it could be. I think we must make every effort to get some younger physicians into leadership positions. I would hope younger physicians would take a more active and interested view of our society if they saw some of their peers in leadership positions.

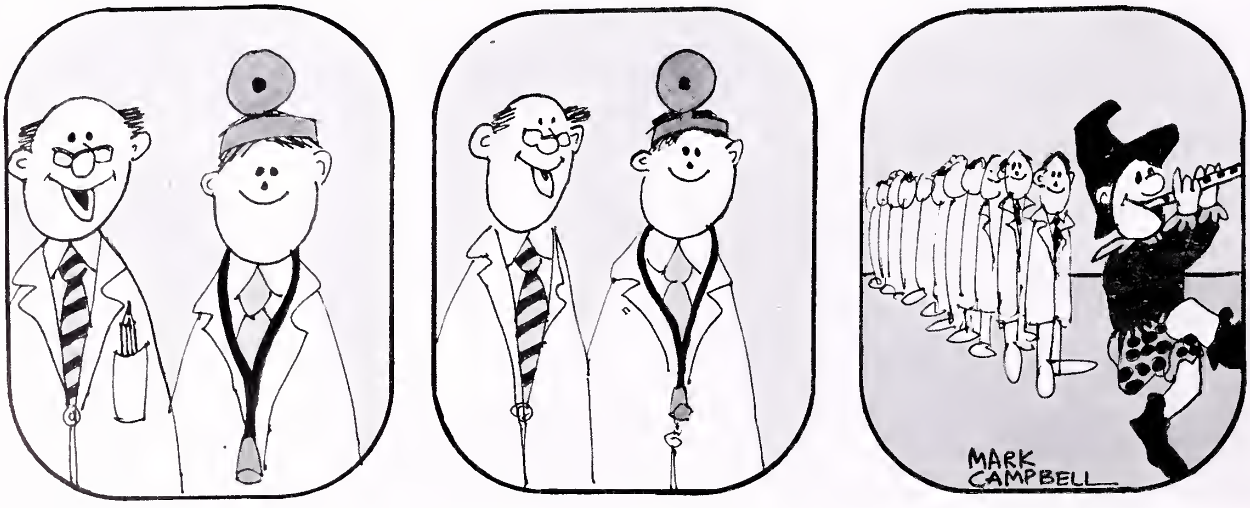
Q: Can you relate some of the more enlightening experiences of your career as a MSMS officer?

A: Some of my more exciting moments certainly include the disagreement between physicians, state government and the Department of Social Services over participation in Medicaid. This problem came to a head at the meeting at which I was elected council chairman. During the first week of my chairmanship it was necessary to call a special meeting of the Council to attempt to resolve the problem. Out of that meeting came the Medicaid Liaison Committee, which has performed such an excellent service for the medical profession and the unfortunate patients in the state who require Medicaid. The activities of Dave Siegel, Jim Fryfogle and others in this field have been outstanding and this has been one of our very worthwhile activities.

The so-called professional liability crisis of those years and the legislative activities leading to the Dively-Demlow Report, the establishment of Brown-McNeely, the changes in the statute of limitations and other legislative developments of the mid-1970s, made for an exciting time. The most fruitful and activity at that time was the formation of MPMLC. MSMS, of course, spearheaded formation of this company, which now is insuring upwards of 4,400 physicians throughout the state. The early leadership of Vern Bass in the development of the company must be mentioned, and the more recent rapid growth and expansion of activities have been most rewarding.

In conclusion I must say that aside from the intensely rewarding aspects of 40 years in the private practice of medicine, my years of MSMS activity, and more recently my activities with MPMLC, have been the highlight of my professional life.

Doctor Quick-Draw



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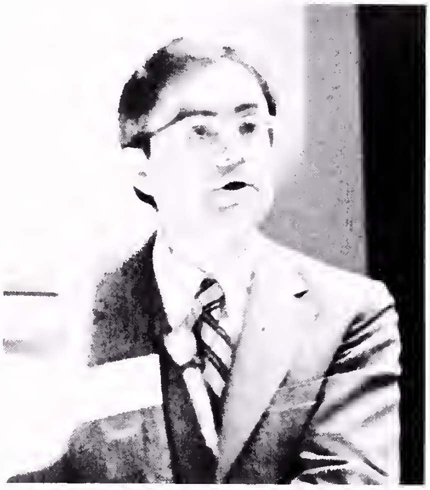
MSMS hosts chiefs of staff

Eighty-five Michigan hospital chiefs of staff and chief medical officers gathered at Long's Convention Center, Lansing, March 25, for an MSMS-sponsored conference on their concerns. The conference was the initial project of the new MSMS Committee on Medical Chiefs of Staff, which aims to help those physicians better meet their challenges, and to provide better communications between them and MSMS.



Thomas G. Dehn, MD, Good Samaritan Medical Center, Milwaukee, discussed how to develop effective input to hospital decision-making.

Almeta E. Cooper, JD, assistant director, AMA Health Law Division, provided insight to the relationships of the medical staff with the hospital governing body and administration.

The role of the chief of staff was the topic of Morgan M. Meyer, MD, of Memorial Hospital, DuPage County, Elmhurst, IL.

State Sen. Edward Pierce, MD, Ann Arbor, left; Grand Rapids otolaryngologist Robert D. Burton, MD, center, and Muskegon surgeon Donald K. Crandall, MD, right, enjoyed a lively discussion at the recent legislative retreat sponsored by the Michigan Society of Internal Medicine. Doctor Burton is chairman of the MSMS Committee on Public Service and vice speaker of the MSMS House of Delegates. Doctor Crandall is MSMS president-elect. Both also are AMA delegates.

Begin cultivating techniques today for tomorrow's competitive marketplace

The irony in the personal organization of most practicing physicians is that these professionals who have spent years in a highly demanding scientific discipline appear to be neither scientific nor disciplined in the management of their professional activities. The same minds that are capable of mastering methodical diagnostic and treatment protocols are often adrift in a Sargasso Sea of aimless time management.

The purpose of this section is to provide guidelines for busy practitioners to use in organizing their professional time in a cost-effective manner.

The first step in effective time management is to convince yourself of the degree to which you are guilty of time-wasting behavior. There are many systems for doing this; for example, some experts encourage persons to keep a meticulous log of their activities for two weeks or longer. However, most busy professionals find this approach to be more painful than their time-wasting illness.

Many studies, by such authorities as Drucker and Mackenzie, have shown that there are recurring patterns in time-wasting behavior. Interestingly, these patterns appear in the behavior of persons in other countries as well. The leading time-wasters are: 1) telephone interruptions; 2) unscheduled visitors; 3) poorly planned meetings; 4) unanticipated problems in the workplace; 5) inadequate goals, priorities and deadlines.

Physicians are troubled by all these as well as some that are more common to the medical profession: unrealistic time scheduling; inability to say "no;" cluttered desk syndrome; and ineffective delegation. There are, of course, many other time leaks that plague the unwary practitioner but these provide an initial list for persons seeking a starting point for better time management.

There are some simple questions to ask as you analyze the cost-effectiveness of your daily activities:

- What happens if I don't do this?
- Could I delegate this activity?
- Am I spending too much time on it?
- How does this contribute to the profitability of my practice?

Speaking of profitability, consider the impact of your personal inefficiencies on the productivity of your colleagues and subordinates. In group practices where examining rooms and ancillary personnel are often scheduled on rather tightly controlled time segments, an inefficient or slow-working member soon finds himself the target of criticism.

Improving personal productivity

Surrounded as they are by an exploding technology, physicians often are reluctant to let any opportunity for self-improvement slide by. This results in paper paralysis, the chief symptom of which is the inability to throw away any journal, newsletter, flyer or brochure that comes into your possession. Cardboard boxes, filing cabinets, manila folders and briefcases bulge with printed items that are waiting to be carefully mined for the priceless nuggets of information contained therein.

SOLUTION: Firmly resolve to DO SOMETHING with any piece of paper you pick up. One highly recommended procedure is to quickly deposit the item in a large 30-gallon wastebasket that you have conveniently placed next to your desk or workstation. Set up several file folders to use when reviewing your mail: Priority Action; Delegate; Read When I Get a Chance; File.

"Throw-away" journals are generally well-named and can be easily dispensed with. After scanning the table of contents of several issues and finding little of value, have your secretary write and have your name removed from the mailing list. In any case, don't keep huge stacks of journals for future reference, set up a clinical material filing system and keep specific articles in these files. Ruthlessly tear out the useful material and throw the rest away.

In dealing with correspondence, pencil a few guiding comments in the margin and let your secretary prepare the response for your signature. Often the quickest response to a memorandum is to write your response on the memo, make a copy for your file and return to sender. In any case, DO IT NOW. Don't set it aside to be answered later. Another time-waster is the largely unnecessary practice of proofing each letter before you sign it. If you don't trust your secretary to properly prepare the letter get a new secretary.

In dealing with the seemingly endless supply of meeting announcements that trumpet the merits of continuing education opportunities, keep your full-year scheduling calendar (you DO have one, don't you?) handy when you sort your mail. Mark the best meetings on your calendar, have your travel arrangements made, and throw away the rest.

Check timewasters

Getting back to the list of time-wasters listed earlier, there have been whole books written about each. Here are some tips that will prove useful until you have the time to study the problems more extensively.

Telephone Interruptions – Have your calls screened according to some clear guidelines, e.g., a list of persons to whom you are always available, method by which the deflection of calls is to occur, etc. When you are on the phone, set a time limit (some persons use an egg-timer), tell the person that you can only speak for a minute or two, say "thanks for calling" and end the conversation.

Unscheduled visitors – Rise when they enter and do not encourage them to be seated, walk toward the door (and through it if necessary), do not give open-ended responses to their comments, and ask when would be a good time for you to get back to them.

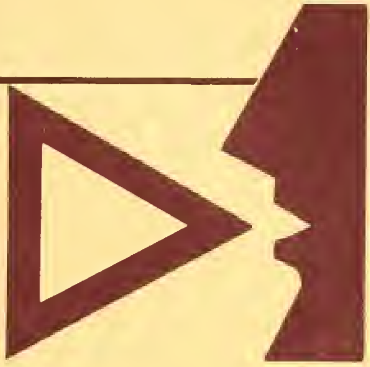
Poorly planned meetings – If you are the meeting planner, develop better agendas, send cogent information in advance of the meeting, set time limits and define a goal for the meeting. If you are attending, ask for an agenda, make sure you need to attend, inform the chairman that you must leave by a certain time and be sure you are properly prepared with background information.

Unanticipated problems in the workplace – Surely you're familiar with Murphy's Law, so plan some flexible time into each day's schedule. Most importantly, give your subordinates the authority and security it takes to resolve problems on their own. Many persons are the victims of their own egos, feeling that only they have the ability to resolve problems. Anticipate and delegate are the key words.

Inadequate goals, priorities and deadlines – Plan each day's activities the night before and have a written list of "Things to Do." Share your plan with your colleagues and subordinates, then set a list of priorities for the day along with a time frame for accomplishing each goal. This sounds so rudimentary that it is astonishing how few physicians actually follow any such procedure. Most tend to slavishly schedule their days and months on the basis of antiquated habit. Ask yourself how the events on your calendar are affecting the plans and priorities you have set. Assume control of your life by evaluating each activity on the merits of its effect on your established goals.

Effective personal organization is a learned skill that only requires you to use the inherent ability that makes you a competent physician — an orderly approach and commitment to a goal. The marketplace in which medicine will be practiced is going to be a highly competitive one in which the words productivity and cost-effectiveness often will be heard. Now is the time for you to begin cultivating the behavior and techniques that will enable you to keep pace.

This article is excerpted from a larger section on practice management being prepared for the MSMS members' manual. "Meeting the Challenge of the 80s." The manual is the project of the MSMS Committee on Public Service, chaired by Robert D. Burton, MD, Grand Rapids. Excerpts will appear in Michigan Medicine *throughout 1982. They are designed to be removed easily and saved for reference.*



Your image is important to your success as a practitioner

Are you well thought of in your community — not just by your colleagues and patients; but by other health care professionals, local businesses and the public at large?

Studies have repeatedly shown that, as you are a member of the medical profession, you are held in high regard by most persons. But do people know and respect you as an individual?

These questions probably arouse in you the suspicion that you are about to receive another of the seemingly interminable lectures on the importance of good public relations. Regrettably these same lectures also remind you of the not-so-goodnatured ribbings that some of your colleagues have received when their names and statements have been splashed about the papers, radio or television.

The fact is, like it or not, that public understanding of and support for your professional activities will be increasingly important to the success of your practice. In some areas, consumer groups are already distributing "guides" which rate the relative merits of area hospitals. Is it too far-fetched to imagine similar guides with medical practices as their subject?

In general, most of us are inclined to leave public relations to our professional societies. But you should recognize that in our increasingly competitive environment, the good wishes of a wide range of "publics" may be important to the success of your practice.

There are many linkages between you and your medical practice and these publics. Certainly the hospitals in your area, with their medical and administrative staffs, boards of trustees, volunteers and ancillary service providers, have an immense capacity to contribute to or detract from your professional success. This is also true of the persons who are involved with social service and governmental agencies, regulatory groups, third-party payers, community service organizations and the ever-present news media.

Each of these "publics" presents its own set of problems in terms of maintaining a good image. Perhaps it will be easier for you to determine how or if you will communicate with these groups if you follow one of the definitions of public relations: "Doing good and getting credit for it." The secret is "getting credit" for the good you do without appearing overly self-serving.

There are many guides to dealing with the news media, one of which is available from MSMS Communications Department.

In dealing with the other "publics," you should be aware that direct communication is the most effective way of reaching them with your information. One way that has proven its effectiveness is to appear as a speaker before community and professional groups. It is no accident that physicians who appear frequently on the speakers platform tend to have successful practices. If you fear criticism from your colleagues, remember that reaching out to the public enhances the understanding and appreciation of the medical profession.

Above all, recognize that the most important "public" you must reach is your own group of patients. Nothing will have a more favorable impact on your image than to have your patients speaking in glowing terms about you to their friends.

Take time to evaluate and improve your communications with your patients. Your image is important to your success as a practitioner.

Take time to get credit for the good you do.

This article is excerpted from a larger section on practice management being prepared for the MSMS members' manual. "Meeting the Challenge of the 80s." The manual is the project of the MSMS Committee on Public Service, chaired by Robert D. Burton, MD, Grand Rapids. Excerpts will appear in Michigan Medicine *throughout 1982. They are designed to be removed easily and saved for reference.*

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	PERSONAL			
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	PROFIT SHARING			
	OTHER			
STOCKS	MARKETABLE			
	CLOSELY HELD			
	BANK ACCOUNTS			
	BONDS			
	PARTNERSHIPS			
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Auxilians cut through fog of legislative process

By Barbara Grennan
Muskegon

The Michigan State Medical Society Auxiliary had another successful Legislative Day March 10. An annual event of many years, this day brings together auxilians from all over the state for the latest information on legislative issues in addition to meetings and discussions with their legislators. Organizer this year was MSMS/A Legislative Chairman Bev Jensen of Grand Rapids.

The agenda always includes a run-down of pending medical legislation by Bruce Ambrose, MSMS Manager of Government Relations. This is one of the most informative parts of the program as it supplies auxilians with concise information about medically related bills, their current status in Lansing and what the state society's position is in regard to each bill. Auxilians receive a printed resume of each bill and any other related data prepared by the MSMS staff. In past years my own legislator has often asked for a copy to use as reference material.

To further enlighten us, a panel of experts in the legislative process was introduced this year. Each detailed his or her involvement in the evolution of a bill. Senator William Sederburg counseled us on the proper method of impacting legislation. He outlined five significant factors to remember when contacting a legislator.

1. Know your legislator personally.
2. Know the content of the bills that concern you.
3. Be pleasant when contacting your representative.
4. Be sure to seek a commitment from the legislator, and
5. If the legislator responds to your request, return the favor through your support.

Senator Sederburg was an articulate and effective choice to participate in the panel. His comments were most appropriate at this time when we are looking for better ways to use to influence the voting patterns of our elected representatives.

From the MSMS staff, Ellen Vinocur Potash outlined her responsibility as a legislative analyst. About 25 percent of all the bills introduced in each legislative session are medically related: about 1,000 bills per year. Ellen's job is to look these bills over, isolate the most significant ones and then do an in-depth analysis of those for presentation to the MSMS Legislative Committee. They in turn make the decisions as to support and probable course of action.

Kevin Kelly, MDPAC staff coordinator, explained how the PAC supports those candidates who are most likely to look favorably on the MSMS position on pending legislation. He encouraged our support of MDPAC as a regular $50 contributor or a $150 sustaining member.

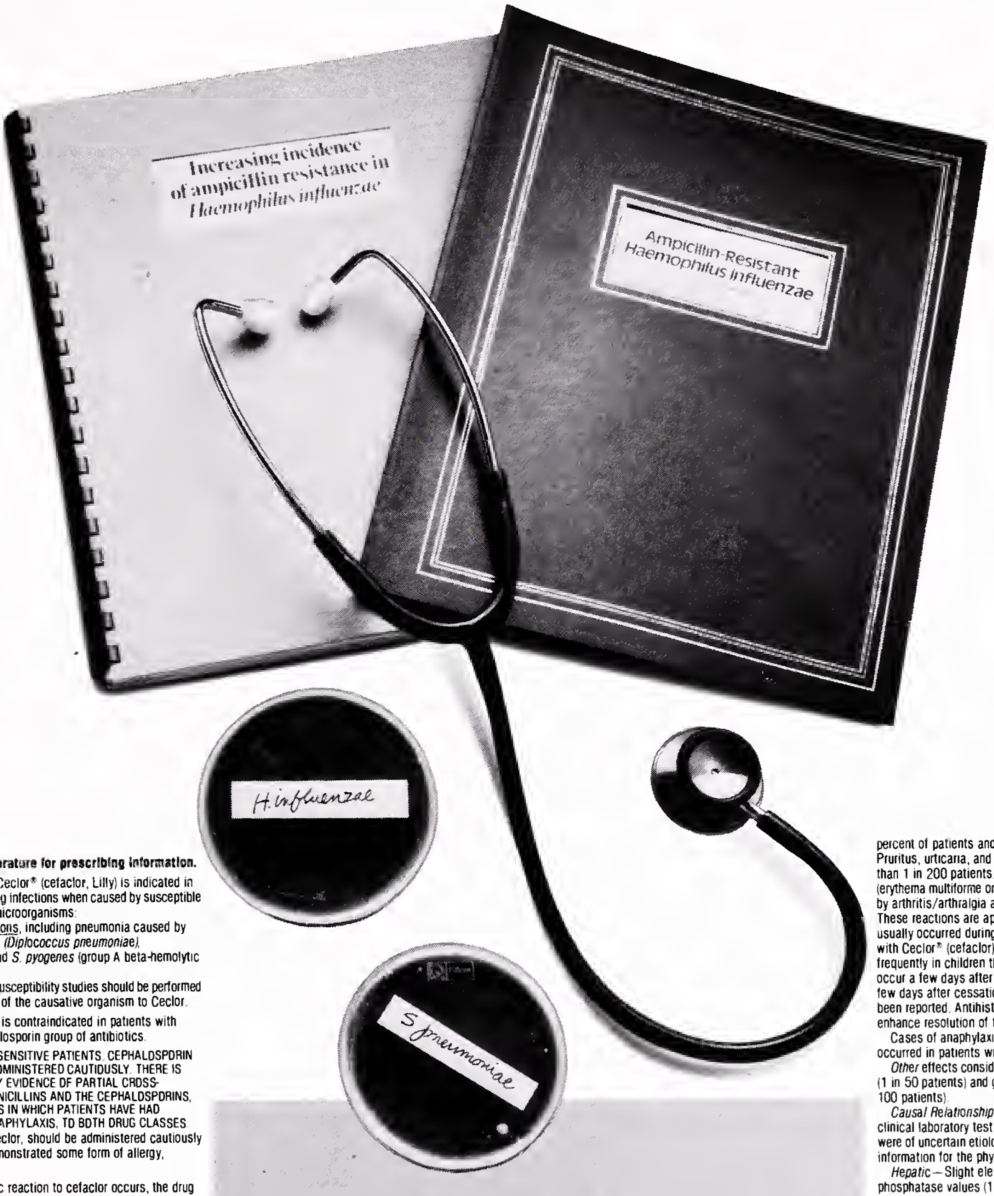
The final panelist was Milt Zaagman, former legislator and now a lobbyist for several organizations, including MSMS. Milt explained what a lobbyist tries to do — influence the legislator to vote for his clients' positions. There are certain criteria necessary to lobby effectively and they are:

1. Be able to communicate the problem and to offer a possible solution;
2. Know how the legislative system works;
3. Establish and maintain trust;
4. Use former legislators who are skilled in the aforementioned areas,
5. Establish a good relationship with the legislator.

It clearly seems that to be able to work within the legislative system in a knowledgeable and productive way one should be trustworthy, personable, knowledgeable, able to communicate and seek commitment while at the same time rendering such support as is needed.

Mrs. Grennan is MSMS/A president for 1981-82.

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin-Resistant Haemophilus influenzae
H. influenzae
S pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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cefaclor

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Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note. Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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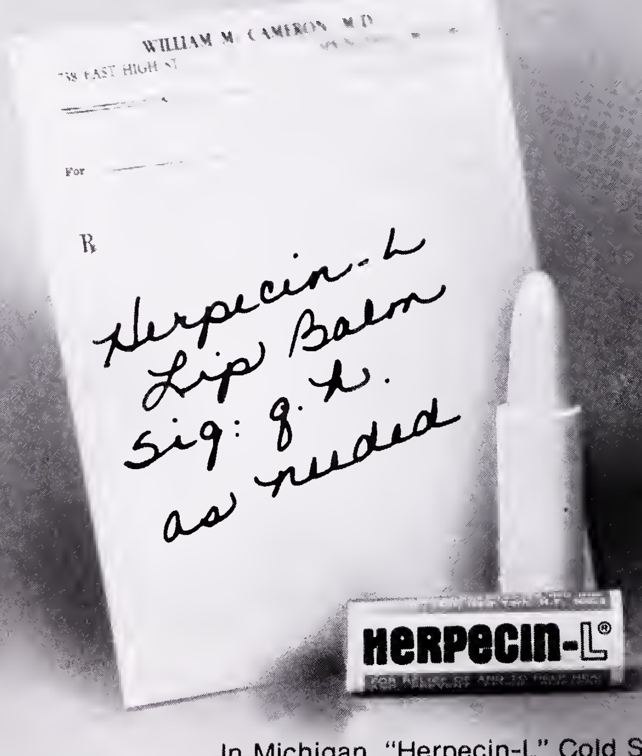
NEWS

By Sheri W. Greenhoe
East Lansing

S. A. Yanitelli, MD, Battle Creek, has been honored with a 25-year service award from the American Academy of Family Physicians. . . . The Rotary Club and community of Jackson recently bestowed five honors upon **Harry Greenbaum, MD,** Jackson. The awards include a Rotary Club plaque for his service to the community, a resolution of tribute from Rep. Michael J. Griffin through the Legislature, a similar resolution from the City of Jackson, a plaque from the Jackson County Medical Society and a letter of commendation from the Rabbi Irwin A. Tanenbaum of Temple Beth Israel. . . . **Dale E. Baker, MD,** Ypsilanti, is MSMS representative to the Access and Oversight Committee of the Michigan Health Data Corporation. . . . **Robert M. Nicholson, MD,** Kalamazoo, is MSMS nominee on the AMA Advisory Committee on Graduate Medical Education. . . . **Jack Ryan, MD,** president, Detroit-Macomb Hospitals Association, has been named to the Michigan Hospital Association Committee on Public Affairs and Education. . . . **Silva Doyle, MD,** is recipient of Michigan State University's 1981 Certificate of Excellence in Teaching for the best volunteer faculty member in Flint. She received the award at a ceremony in Lansing in March. . . . Homer physician **Walter B. Long, MD,** announced recently that he is running for the US Congress on the Republican ticket. He said Michigan is in a severe economic crisis, and "needs intensive care." . . . Governor Milliken announced one appointment and four reappointments to the Michigan Board of Medicine for terms expiring December 31, 1985, subject to Senate confirmation. Reappointments were: **John F. Fennessey, MD,** Grosse Pointe; **James L. Fenton, MD,** Bay City; **Henry A. Kallet, MD,** Chelsea and **Addison E. Prince, MD,** Detroit. Newly appointed was **Charles C. Vincent, MD,** Detroit. . . . **James D. Fryfogle, MD,** Southfield, MSMS President, acted as moderator for the April 24 Conference on the Medical Consequences of Nuclear Weapons and Nuclear War in Detroit. The program was organized by the Detroit and Washtenaw County Chapters of Physicians for Social Responsibility, of which Doctor Fryfogle is a member. Other Michigan physicians on the program faculty were: **William G. Anderson, DO; John R. Caldwell, MD, PSR founder; Thomas Killip, MD; Mark Leventer, MD; Eugene V.D.K. Perrin, MD; Donald L. Rucknagel, MD, PhD; Charles S. Stevenson, MD.** . . . **John Kirkpatrick, MD,** Grosse Pointe Park, chief of the section of general surgery at Harper-Grace Hospitals, spoke at the meeting of the American Society for Parenteral/Enteral Nutrition in San Francisco in February. He spoke about "Alternatives to Total Parenteral Nutrition: Selective Hyperalimentation." . . . The Florida retirement lifestyle of **Mahlon (Mike) Sharp, MD,** formerly of Lansing, was featured in the March 29 issue of *Medical Economics.*

Ms. Greenhoe is editorial secretary to Michigan Medicine.

Dx: recurrent herpes labialis



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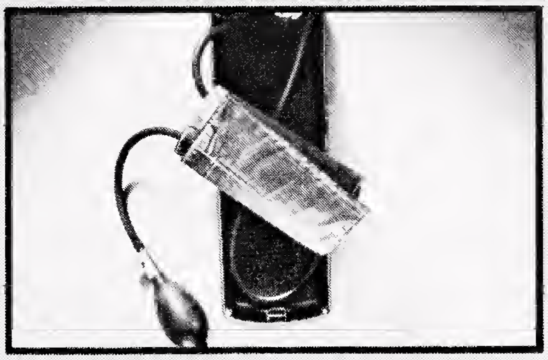

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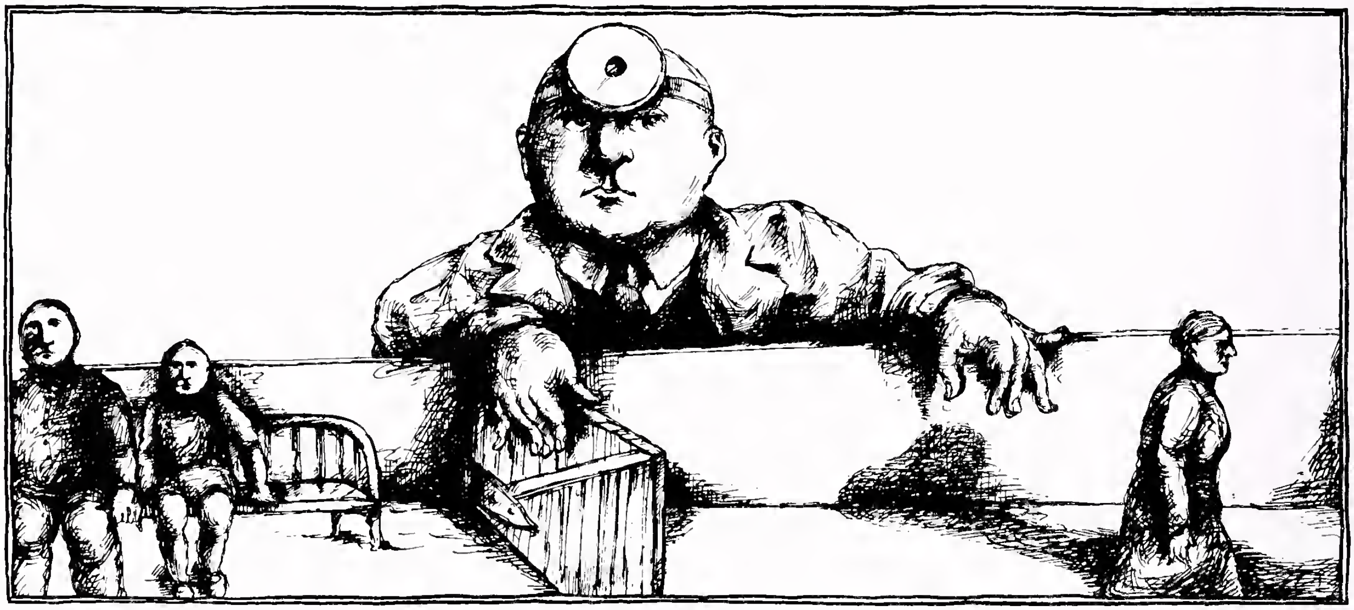
What really happened in the Friedman case

By A. Stewart Kerr
Detroit



Drawing by Geoffrey Moss. Reprinted with permission from the Carnegie Quarterly, Volume 28, Number 2/3, Spring/Summer, 1980.

The medical community is aware that Doctor Seymour Friedman's "countersuit," a litmus paper case, was lost in the Michigan Supreme Court. MSMS continues to get inquiries as to what really happened in this case and what the end result means. A short, non-legal synopsis is therefore given here.

Doctor Friedman, an Oakland County physician, successfully defended a malpractice suit brought against him. The plaintiff attorneys in that case were Messrs. Dozorc and Golden. Subsequently, Doctor Friedman brought suit against Dozorc and Golden and was defeated at trial court level by summary or accelerated judgment, meaning that the case did not even reach trial on the merits. Doctor Friedman's suit was based in part on the theory of malicious prosecution, in part on a theory that the lawyers were negligent in bringing the case without proper investigation, plus allegations concerning abuse of process.

Neither side was satisfied. Both sides appealed to the Michigan Court of Appeals. The Court of Appeals affirmed in part and reversed in part and the case was appealed to the Michigan Supreme Court. The Supreme Court ruled on the particular case and also broadly considered what remedies may be available to physicians by way of countersuit. The Court made a clean disposition of the *Friedman* case and of the entire scope of countersuits.

The Supreme Court held that Dr. Friedman had not stated an actionable claim on the theory of negligence because an attorney owes no duty of care to an adverse party in litigation. Doctor Friedman did not state an actionable claim on the theory of abuse of process because there was no showing that the defendants committed any irregular act in the use of the legal process. The abuse of process phase was dismissed out of hand because there was nothing to support it. Finally, the Court held that Doctor Friedman failed to state an actionable claim on the theory of malicious prosecution because his case did not allege interference with his person or property sufficient to constitute a special injury.

Put differently, Doctor Friedman lost on all possible theories that were advanced in his behalf. That is the bottom line.

Michigan physicians seem particularly concerned with the Court's statement that a lawyer owes absolutely no duty of care to the adverse party in a law suit.

The Court pointed out that while the lawyer has an obligation to his client to conduct a reasonable investigation prior to filing suit, he does not owe an equivalent duty to the other side. Indeed, the Court stated that to set up a duty of care to the opposition is inconsistent with the basic precepts of the adversary system. The Court explained how difficult the evaluations would be for the plaintiff lawyer if he owed some degree of care to each side; the best interests of each side would frequently be in conflict. Thus the allegations of negligence fell because of the decision that plaintiff lawyers owed no duty to Doctor Friedman's side; therefore there was nothing about which they could be negligent.

As to the theory of malicious prosecution, the Court pointed out that Doctor Friedman would have to show special injury, the absence of probable cause for the lawyers hav-

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Mr. Kerr is MSMS legal counsel.

ing brought the original case and, importantly, malice or a purpose other than that of securing the proper adjudication of a claim. Doctor Friedman could not, on the pleadings, meet these tests.

Prior to this litigation, it was generally thought that in the countersuit arena lawyers could be sued for malicious prosecution, although proofs might be difficult. It was hoped that the *Friedman* case would establish, additionally, the theory that in Michigan lawyers could also be countersued for their negligence. As noted above, the heretofore plausible malicious prosecution theory fell in this case simply because there were no specific grounds to show malicious prosecution.

Importantly, and perhaps dishearteningly for the medical profession, the Court simply blasted out of existence the possibility that lawyers could be countersued on a theory of negligence. That is the major thrust of the case from a legal standpoint.

In one of the concurring opinions Justice Levin pointed to the interesting possibility of addressing the problem of groundless litigation by a remedial court rule to compensate malpractice defendants such as Doctor Friedman. Under such a proposed court rule, the trial judge who heard the groundless malpractice case would, upon proper motion and by supplemental hearing, ascertain whether the litigation was so meritless as to warrant the court awarding full and true costs to the countersuing doctor. Such awards could be against the patient-plaintiff, the plaintiff-lawyer, or both.

As has been publicized elsewhere, MSMS is extremely interested in the promulgation of such a court rule and has tendered to the Supreme Court possible language for such a rule, including: the grounds, the time limitation, that the hearing should be by the judge who heard the underlying cause, that the rules of evidence would not be strictly applied, the nature of the award or recovery, including described expenses, and possible recovery for injury to reputation as well as loss of income producing time.

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These cases could bear on every MD

MSMS Legal Counsel A. Stewart Kerr submits the following analyses of recent legal developments in Michigan, for MSMS members' study. Both of these developments may directly affect Michigan physicians' daily medical practices. *Michigan Medicine* is happy to route the following reports to members.

Standard of practice for informed consent upheld in high court

MSMS entered this case in the Spring of 1981, filing in the Supreme Court as amicus curiae. This was a dental malpractice case in which one of the issues was the question of informed consent. The defendant dentist testified on cross examination that he did discuss with plaintiff the possible residual numbness that could arise out of the dental surgery. Importantly, the dentist also testified on cross examination as to his knowledge of the standard of care for oral surgeons in explaining the hazards to patients. For reasons unknown, plaintiff's lawyer did not produce any other witness relating to the standard of care for informed consent. The trial court therefore gave a directed verdict for the defendant dentist because of plaintiff's failure to establish the prevailing standard. This was affirmed by the Court of Appeals.

When the Supreme Court took the case, it asked the parties to consider (1) whether the record contains sufficient evidence to warrant the case going to a jury and (2) whether the Supreme Court should adopt the Maryland rule in *Sard v Hardy.*

We were not concerned about the issue of whether the case should have gone to a jury. We were greatly concerned that the court not adopt the *Sard* rule which, simply put, would virtually eliminate the requirement of a professional standard of practice for informed consent. *Sard* merely adopts a lay standard of what a reasonably prudent patient is expected to be told, whereas the law in Michigan is that expert tesimony on the standard is required, ordinarily from an expert brought in by the plaintiffs but which may be elicited from the defendant himself.

The Supreme Court found on issue number one that Dr. Jaskolski's own testimony as to the standard of care was sufficient to preclude a directed verdict for plaintiff and, hence, that the case is remanded to the jury for a trial on the facts. The second issue was not addressed by the Court because of the factual issues.

This result is satisfactory to MSMS. As the court stated, having so decided on point number one, it was not *necessary* even to *consider* point number two, namely, *whether the rule in Sard v Hardy should be adopted in Michigan.* While we might have preferred a resounding rejection of the *Sard* rule, the case did come out all right for our purposes at the Supreme Court level. We believe that a very firm amicus stand against introduction of the *Sard* rule was justified and received Supreme Court consideration.

The FTC and ethical standards in advertising

As you may know, the U.S. Supreme Court heard the AMA appeal in its FTC case on January 11. The problems of ethical standards on advertising, solicitation and contract practices are not found in the MSMS case. However, a vigorous argument is made by the AMA that the FTC lacks jurisdiction over non-profit professional associations because the AMA is not in the business of making a profit for itself or its members. The FTC asserted that such jurisdiction does exist because a substantial portion of the AMA's activities is directed toward enhancing the profits of its members and those activities are more than incidental in nature. Thus, it is claimed, the AMA is carrying on business for the profit of its members within the meaning of the FTC Act. This was debated at some length and a number of lively questions came from the bench directed to lawyers on both sides.

To a lesser extent, arguments were had on the AMA's first amendment rights of free speech. This appears to have been a non-vital argument in the context of the AMA facts but is of somewhat more significance in the MSMS case. Any Supreme Court ruling on the jurisdictional aspect of the AMA case could have direct significance in the MSMS litigation. A pronouncement on the first amendment issue, unless extremely broad, will probably have no value as a precedent if the MSMS case comes before the high court.

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CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable tc become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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J-9043-4 July 1981

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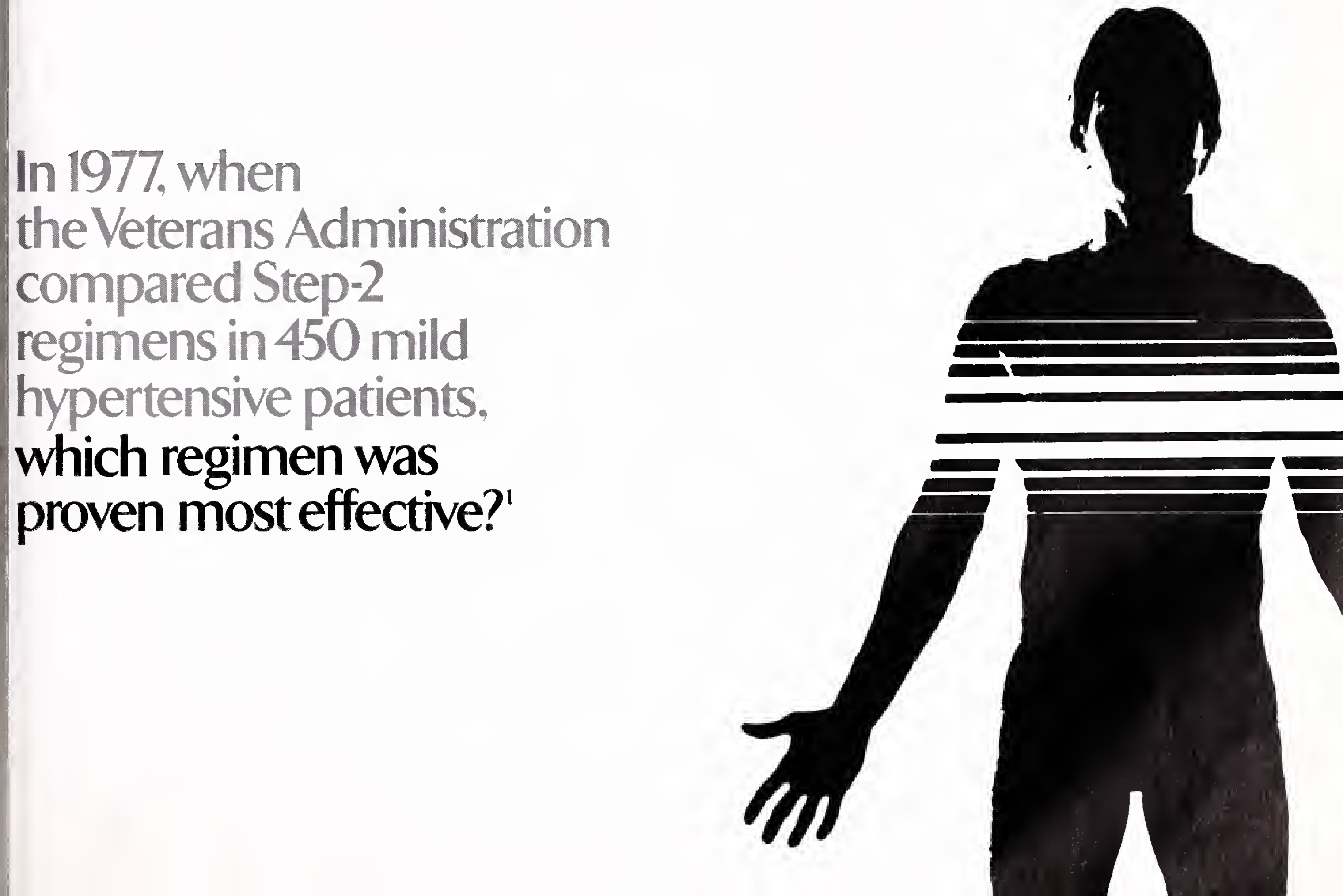
In 1977, when
the Veterans Administration
compared Step-2
regimens in 450 mild
hypertensive patients,
which regimen was
proven most effective?[1]

Autobiography of an alcoholic medical student

The equivalent of one medical school class of students is lost each year to alcohol and other drug addictions. Some of these students never return to medical school. It has come to my attention that addiction, as a cause of poor performance in medical school, is frequently not diagnosed. If it is suspected, the medical student often is not directed to adequate skilled help.

The autobiography that follows was written by a medical student who was asked to leave school at the end of his third year. It is significant in that it demonstrates the progressiveness of the disease of alcoholism and the inadequate care received until the student met a physician who had personally experienced the disease of alcoholism.

The Michigan State Medical Society Program to Assist Impaired Physicians is very willing to help with any medical student having addiction problems.

The student, who has written his autobiography, is receiving skilled counseling and regularly attends meetings of Michigan Doctors in Alcoholics Anonymous as well as other AA meetings.

His progress in recovery has been very good and with continued recovery it will be gratifying to endorse him for return to medical school. Such a student, once he becomes a practicing physician, will be a valuable asset in the care of other persons with addictive disease.

— Ward M. Smathers, MD, Lathrup Village. Doctor Smathers is cochairman of the Intervention Committee of the MSMS Program to Assist Impaired Physicians.

I can't say for certain when I took my first drink of alcohol, but I can say with some assurance that it was when I was very young.

I've seen family movies of my father and his cronies jokingly giving me swigs of beer from their bottles when we gathered for holidays. Their laughter seems forced in these scenes. But the look on my face is unmistakable; the taste was horrible!

Somewhere along the line I was convinced of my earlier folly and came to appreciate not only the taste but everything related to alcohol. It was a slow process which seemed to grow as I wasn't looking.

As an altar boy I particularly enjoyed serving at 6 AM mass because the old priest who celebrated then had a habit of leaving the wine cruet half full. The nun who cleaned must have wondered at the prelate's sudden thirstiness whenever I was scheduled for that duty.

Similarly in high school, I never missed an opportunity to participate if there was the chance that drinking would be part of the activity. Not that I was an anti-social underachiever; in fact, it was really the opposite case.

But no matter how natural or coincidental these early encounters with alcohol appeared, for me there was always a secret exhilaration of having had an experience that was better because I was drinking.

My serious drinking began in the Army. Of course, drinking was still a lot of fun and most of mine was associated with carousing after hours out in the S. Korean villages with my fellow troops. It was an endless challenge to discover how drunk we could get and not be fleeced in our pursuit of venereal diseases.

But now I started drinking for relief; from the loneliness, the boredom, and other unnamable anxieties which had become part of my life. No matter how bad the day or negative the emotions, I knew that consolation was just a few drinks away and damn the inevitable hangover!

I also broke that invisible barrier of duty at this point and began drinking whenever I needed to. Although I had achieved accelerated advancement regularly since basic training, I was caught one night drunk and asleep at my radioteletype when I should have been passing important messages.

The fact that my commander was one of my regular drinking partners saved me from a full court martial but not from a demotion in rank, reduction in pay and transfer to a field unit from my privileged headquarters company.

When I returned home, I began in earnest to pursue my lifelong dream of becoming a doctor. This new adventure marked my first attempt to moderate my drinking. Certainly, I rationalized, my heavy drinking in the service was due to the harshness of the situation. Now I was where my future lay and my behavior would reflect my resolve to attain my goal.

I began my undergraduate work and progressed well. But again the familiar fears appeared. I knew that medical school was a longshot. I inwardly feared that someday one of my college professors would look up from his podium in the middle of his lecture and, while I stood in the midst of my classmates who were obviously brighter and more industrious, enumerate exactly how bad I really was.

I never spoke of this fear to anyone but it was very real. And I knew how to allay it, which I continued to do with increasing regularity. I began to drink even heavier on weekends, looking forward to Friday night when I could really get 'mellow.'

I had my first blackouts at this point and would wake up on Saturday afternoons having no recollection of how or when I had arrived home. My group of friends had become students like myself. I liked to consider that we were the 'avant garde' who would cut classes to spend our time at the local bars around campus, solving the world's problems while we got drunk.

My acceptance to medical school was a jolt of high voltage. My god, I had made it! Joy, astonishment and terrible foreboding. Could I cut the mustard? I resolved yet again that I had to get my drinking under control.

I had begun to get a little desperate. After neglecting my spiritual self for years I suddenly felt a great need to make contact with something more powerful than me. I bought books on theology and meditation which I would study in the evening with my twelve pack of Stroh's on the floor; I had long since given up keeping them in the refrigerator since I found it too inconvenient to get up so often to get another can.

When classes began, I sought out other students who might also feel this same spiritual need. After several encounters I found my friend, a true spiritual seeker who drank Budweiser!

The story from this point became frustration, pain and small victories of eluding detection one more time. I had experienced difficult course work in undergraduate school, but never so much at once. It was unrelenting.

I found myself constantly looking for ways to get more drinking time. I would cut all the classes I could and hope that the scribe notes were coherent. Since my wife was working during the day to support us, I found it easier to drink most heavily in the morning, nap in the afternoon and then study at night. In an effort to look better in front of the administration and my peers, I had taken fellowships and graduate assistantships. These gave me access to labs and offices where I could study for the evening and pursue my drinking. Because I was learning everything from textbooks, including anatomy lab where I would surely be detected as a drinker, my personal medical library became the best in the school!

It's laughable to realize I was studying medicine and not perceiving what I was doing to myself. I was finally called in by a fine instructor who had seen me in clinics. She was concerned and tactful, the right approach with any sane individual. But by this time my thinking had become so paranoid and convoluted that it was like taking a garden hose to the Chicago fire.

I went to the psychiatrist that she suggested. He was supportive and intelligent. He told me, after some time, that I was passive/aggressive and that I had better cut down on my drinking. Well, ok! Here was a man I could live with, someone who wouldn't tell me to *quit*.

More people called me in and I went to more psychiatrists and psychologists. They all had different approaches and were willing to support me in my efforts to control my drinking. And none of it was doing any good: none of the threats, none of the sanctions. I was in pain most of the time and my life had become misery.

It was at this point, when I was sure that I would soon be thrown out of school and lose it all, that I met the man who finally managed to get through my stupor. Forget about the analysis and theories, he said. Forget about control and moderation. Forget about all your rationalizations because you are a drunk. If you don't

Continued on page 278

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study),
which Step-2 regimen was preferred and was deemed effective without significant adverse effects?[2]

NEWSFRONTS

Henry Ford Hospital's Digital Video Subtraction Angiography (DVSA) instrument uses television techniques to show physicians if their patients' blood vessels are functioning properly or if they have blockages.

HFH's is the only known unit in Michigan.

According to William Eyler, MD, chairman of Diagnostic Radiology at HFH, "For the patient the DVSA has three main advantages. We can inject the contrast material into a vein instead of an artery with much less risk of morbidity; because it can be done on an outpatient basis, it costs less; and, it causes much less discomfort."

For some intra-artery injections, the DVSA uses about one third of the dye used in an arteriogram.

With the DVSA, the entire procedure usually lasts only about 30 minutes as compared to the hours often involved in conventional arteriography preparation, procedure and follow-up. DVSA uses the computer to convert impulses of the x-ray beam into numbers and translate them instanteously into an image on a TV screen. It compares images taken at different times during the test — form a pre-injection image, called a mask, to post-injection as the dye flows through the blood vessels.

A blood test for prenatal screening of open neural tube defects is now available to Michigan physicians through the Medical Genetics Unit at Michigan State University.

The test, which screens for alpha-fetoprotein (AFP), is 80 percent reliable in detecting in utero such defects as spina bifida and anencephaly, said Gerald Holzman, MD, professor of obstetrics, gynecology and reproductive biology at MSU.

"As a nonspecific marker, AFP screening is not in itself a sufficient diagnostic test," Dr. Holzman said. "Other techniques such as amniocentesis or sonography are necessary to confirm a diagnosis."

Of those women screened, it is estimated that five percent will have an elevated result requiring a repeat test. In two percent of the population an amniocentesis may be indicated. Only one or two out of 20 women having amniocentesis would be expected to have an abnormal result.

"However, AFP testing should not be limited to a high-risk group," Doctor Holzman said. "since less than 10 percent of neural tube defects occur in pregnancies to women who have previously affected children."

The AFP screening program is open to any licensed physician who agrees with the program guidelines. An information booklet is available by contacting the Prenatal Diagnosis Group, Medical Genetics Unit, 123B Life Sciences Building, Michigan State University, East Lansing, 48824; 517/353-2032.

A remotely programmable insulin pump has been successfully implanted for the first time in an insulin-dependent diabetic man, according to a report in the April 2 *Journal of the American Medical Association*. The device has been functioning well for over a year.

Physicians from the University of New Mexico School of Medicine in Albuquerque, led by endocrinologist David S. Schade, MD, associate professor of medicine, implanted the pump in January 1981 in a then 41-year old man who has had diabetes since the age of five years.

With use of the implanted pump, the patient's blood sugar levels (which fluctuate with food intake and exercise) were controlled better than they were when he was giving himself daily injections of insulin during a pre-implant evaluation.

The insulin pump consists of a silicone rubber insulin reservoir (implanted in the abdomen just below the skin so that it can be refilled by injection) and the sealed pump itself, which is controlled by a palm-size, push button unit permitting the recipient to program and measure the rate and quantity of insulin delivered by the pump. The insulin is continuously pumped into the abdomen and absorbed into the bloodstream by capillaries.

The first published report of a study of synthetic human interferon in cancer therapy discloses that four of eight patients with advanced disease showed tumor shrinkage after treatment with an interferon prepared using gene-splicing techniques.

The study appearing in the March 26 issue of the *Journal of the American Medical Association* proves that at least one synthetic interferon has antitumor activity.

Interferons, a class of proteins secreted by animal cells, have been shown to confer resistance to viral infection and are being studied for their effect on cancer. Naturally produced human interferon, however, is scarce, limiting the scope of the studies. The production of a synthetic interferon by recombinant DNA techniques — otherwise known as gene splicing — promises an ample supply.

Clinical trials with the synthetic interferon were conducted at Stanford University Medical School by a team of researchers, including Thomas C. Merigan, MD, head of the school's department of infectious diseases and one of the nation's foremost investigators of interferon.

A federal goal to eliminate measles in the United States by October 1982 is likely to be realized, according to a report from the Center for Disease Control (CDC), Atlanta, in the March 19 issue of the *Journal of the American Medical Association*.

Citing CDC statistics, a group of investigators headed by Alan R. Hinman, MD, director of the Centers' immunization division, writes that the nation now is virtually free of measles. During the first 39 weeks of 1981, more than 90 percent of the nation's counties had no reported cases, and only 86 counties (2.7 percent) had reported measles more than twice during the year. A total of 2,668 cases were reported during the first 39 weeks of 1981, a 79 percent decrease from the incidence reported during the same period in 1980 and a 99.4 percent decrease compared to the same period in 1962, the year before measles vaccine was licensed.

A nationwide childhood measles immunization program initiated in 1977 by the Department of Health, Education, and Welfare (now the Department of Health and Human Services) has made the most important contribution to the dramatic decline in measles, according to the CDC report.

Eight new cases of Reye's Syndrome (RS) have been reported in Michigan since our last update, January 21. A total of 21 cases have been reported in the state since Oct. 1, and there have been seven deaths.

RS was preceded by respiratory illness in 13 cases, by chickenpox in five, and by gastroenteritis in two. The other child had a nonspecific prodrome. Of the 21 patients, four were less than 12 months old and two between 12 and 24 months old. Three deaths occurred among this younger group. Four of these six patients were non-white.

During the 1980-81 RS season there was a total of 27 cases with no deaths reported. This death rate is significantly lower than the death rate seen to date this year ($p=0.05$, Fisher's exact test). As well, the proportion of patients less than two years old was significantly lower (one of 27 as compared to six of 17, $p < 0.01$, Fisher's exact test) and may account for the difference in death rates. It is not clear, though, why cases are younger this year.

In the Great Lakes Region, the following states have reported RS cases since October 1, 1981:

Illinois (4)
Indiana (6)
Minnesota (5)
Ohio (19)
Ontario (2)
Wisconsin (1)

The Michigan State University laboratory that developed cisplatin — a widely used, platinum-based anticancer drug — now reports an anticancer drug series that may be even better.

Based on palladium, a rare chemical cousin of platinum, the new compounds, it is hypothesized, may work against intestinal cancers — tumors that cisplatin does not faze.

Devinder S. Gill, PhD, postdoctoral fellow, and Barnett Rosenberg, PhD, professor of biophysics at MSU, announced the new palladium complexes March 31 in Las Vegas at the 183rd national meeting of the American Chemical Society.

"Although earlier palladium-based complexes were only marginally active against cancer," Gill said, "animal tests indicate that the anticancer activity of the new complexes is comparable to or greater than that of cisplatin.

"Moreover, the molecular structure of the new palladium compounds is such that they might be useful in the treatment of stomach, colon and other gastrointestinal cancers for which cisplatin is not effective.

"In addition, our active palladium compounds appear to be less toxic than cisplatin or analogous platinum compounds."

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, **which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?**[3]

New laws mandate Medicare changes

The federal government has made several changes to control costs and improve efficiency in Medicare during the past year. This article summarizes major new provisions involving expanded coverage and increased deductible and co-insurance amounts. This information is printed here to inform physicians as both recipients and providers of Medicare services. MDs may get more complete information from local Social Security offices. Blue Cross and Blue Shield of Michigan also has developed a new "Complementary to Medicare" brochure available at local Blue Cross offices.

Part A Deductible and Co-Insurance

As of January 1, the Part A deductible rose to $260 from $204. This means that for the first 60 days in each benefit period, Medicare pays for all covered services except the first $260. The deductible represents the average daily cost of inpatient hospital care and was increased to keep pace with costs.

Since other co-insurance amounts are based on the deductible amount, they also went up on January 1.

Inpatient Services	Daily Co-Insurance Amount You Pay	
Hospital: 61st-90th day	$ 51	$ 65
Reserve days	102	130
Skilled Nursing Facility: 21st-100th day	$ 25.50	$ 32.50

Part B Deductible

The annual Part B deductible amount had been frozen at $60 since 1972. As of January 1, it rose to $75.

Outpatient Surgery

Formerly, Medicare paid surgical facility charges only when surgery took place in a hospital or hospital-owned facility.

The program now will cover the full cost of outpatient facilities for certain specified surgical procedures. A list of the approved procedures is being prepared, and will include many that can be performed safely in a walk-in surgical center or, under certain conditions, in a doctor's office.

If a physician accepts assignment, Medicare now will pay 100 percent of the surgical charge instead of 80 percent.

Payment for services to a deceased beneficiary

A physician's bill no longer has to be paid by the deceased's family or estate before it is submitted to Medicare, even if the doctor does not accept assignment. Since January 1, 1981, if the physician refuses to accept assignment, itemized bills have been reimbursed by Medicare whether or not the physician has been paid. This applies to services furnished October 1, 1979, or later.

Payment to radiologists and pathologists

Formerly, Medicare paid radiologist or pathologist charges for hospitalized Medicare patients. As of July 1, 1981, total payment has been limited to doctors who have filed an assignment agreement for all services provided to Medicare inpatients.

Outpatient physical therapy

As of January 1, 1982, the Annual Medicare limit on outpatient physical therapy provided by independent therapists increases from $100 to $500.

Dental services

Dental services generally are not covered under Medicare. However, since July 1, 1981, Medicare has covered a dentist's services if they are benefits when provided by a physician. Medicare also covers hospital stays for certain dental procedures even if the procedures are not covered.

Home health services

Medicare covers the full cost of home health services.

The previous Medicare limit of 100 home health visits in a benefit period under Part A was eliminated July 1, 1981. The requirement of a prior three-day hospital stay has also been lifted.

Medically necessary home visits under Part B now are unlimited. Patients qualified for home health benefits can receive them even if occupational therapy is required without part-time skilled nursing care of physical or speech therapy.

Optometrist services

Medicare now covers an optometrist's examination for aphakis. Prior to July 1, 1981, an examination was covered only if performed by a physician.

Pneumococcal vaccine benefit

Medicare pays 100 percent of the approved amount for both the serum and administration.

Plantar wart benefit

Although Medicare does not cover routine foot care, it does cover treating warts on the feet, including plantar warts, as of July 1, 1981.

Part B carryover eliminated

Covered medical expenses in the last three months of a year count toward Part B deductibles for that year only. Expenses after October 1, 1981, no longer apply toward the following year's deductible.

Part B open enrollment eliminated

For a while during 1981, people could sign up for Medicare Part B at any time. This is no longer true. Sign-up must occur during the initial enrollment period or the first three months of any succeeding year. There is no limit on re-enrollments after dropping Part B coverage.

(Information for this article provided by Blue Cross Blue Shield of Michigan.)

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Are the results of $100 million worth of government-funded research on hypertension worth reading about?

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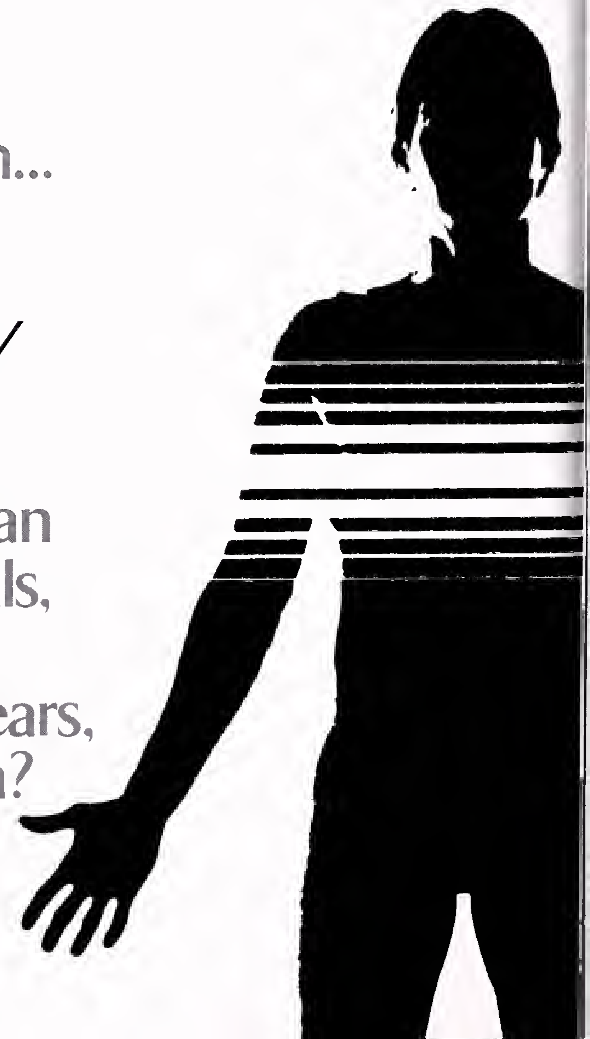

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Ann Arbor 48104

Frank A. Rosenbaum, MD OPH
241 E. Saginaw #210
East Lansing 48823

Lilya Rudoi, MD N
22900 E. Remick
Mt. Clemens 48043

Ruth A. Rydstedt, MD IM
243 Gratiot
Mt. Clemens 48043

Robert G. Saieg, MD OBG
3790 Eastbourne
Troy 48084

A. R. Satyanathan, MD IM/NEP
80600 Van Dyke Box 125
Romeo 48065

Nutan Saxena, MD P
30365 Lyndon
Livonia 48154

David G. Schaefer, MD CD/IM
101 Rochdale A
Rochester 48063

Thomas J. Schnur, MD PD
25815 Harper
St. Clair Shores 48081

Philip M. Setla, MD R
26860 Gyndon
Redford 48239

Ranajit Sil, MD NS
12535 Pine
Taylor 48180

Atindra N. Sinha, MD ORS
23800 Orchard Lake Rd. #210
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Arun K. Singal, MD IM
14551 Southfield Rd.
Allen Park 48101

And there's more proof on the way!

1982 will see the completion of the Multiple Risk Factor Intervention Trial (MRFIT)—a six-year, 12,000-patient study assessing the factors that increase risk of cardiovascular disease. For the management of hypertension, the preferred Step-2 regimen in this study is reserpine-thiazide.

In 1978, in a preliminary report presented to the Epidemiology Section of the American Heart Association (Dallas, Nov 1978), after 12 months of the trial, fewer patients (5.3%) treated with reserpine suffered depression than even the untreated control group (7.7%)!

Please see references and brief summary of prescribing information on last pages of this advertisement.

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ALCOHOLIC/*continued*

quit, you will surely die. That simple.

He was right.

I date my recovery from the day I met that physician. And although it was a few days ago, I'm beginning to realize that I've just scratched the surface of what a sober life can mean. I know I will never be cured, but I also know that I can keep myself in remission as long as I wish to. After all the years of conning other people and most especially myself, I've found the best way to honesty around the tables at Alcoholics Anonymous.

After all the desperate avoidance and fruitless searching, I found the very people I had shunned were the people I was most like! I had thought myself better; after all I was going to be a doctor! And yet here at the AA tables were doctors, lawyers, janitors and all the rest of us!

It would be difficult in a space shorter than a small novel to touch on the new life I've been blessed with, thanks to some very special people and the AA program. But just ask me! I'll be glad to let you know!

NEW MEMBERS/*continued*

H. Charles Slater, MD OPH
4150 S. River Rd. C
St. Clair 48079

Carl Sloth, MD IM
2100 Hemmeter Rd.
Saginaw 48603

Ronald E. Smith, MD R
5944 Andersonville Rd.
Waterford 48095

Ho Suck Song, MD P/N
Mill Street Prof. Bldg.
Adrian 49221

Carolyn Sprague (Student) WSU
3278 Coolidge
Royal Oak 48072

Andrew M. Stadnyk, MD FP
622 North Ave.
Battle Creek 49017

Paula Suit (student)
1209 Island Dr. P101
Ann Arbor 48105

James M. Switzer, MD R
22840 Nottingham Lane
Southfield 48034

Elaine H. Tan, MD PD
2370 Walton Blvd.
Rochester 48063

John M. Turnbow, MD PD
6071 W. Outer Dr.
Detroit 48235

Mark P. Vanden Bosch (student)
1912 Geddes Ave.
Ann Arbor 48104

Keith Van Oosterhout, MD FP
202 Kensington Ave.
Flint 48502

John R. Van Timmeren, MD PD/EM
21 Michigan St., S.E. #525
Grand Rapids 49503

Anthony N. Vettraino, MD FP
29829 Telegraph Rd. #203
Southfield 48034

Kay H. Vydareny, MD DR
2233 Wilshire, S.E.
Grand Rapids 49506

Dennis A. Wagner, MD FP
330 N. Saginaw
Sanford 48657

Andrew A. White, MD FP
2 Southwestern Med. Clinic, PC
Berrien Center 49102

William D. Zeichner, MD GS
4555 W. Maple
Birmingham 48010

Salutensin® **Salutensin-Demi™**

(Hydroflumethiazide, Reserpine Antihypertensive Formulation)

Brief Summary of Prescribing Information (12) 10/27/78

For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

Legislative breakfast

The Oakland County Medical Society holds several legislative breakfasts during the year, under the direction of Frederick V. Minkow, MD, left below, OCMS legislative chairman. The breakfasts draw approximately 30 physicians and legislators each time. They debate a key current legislative issue and then hear a physician describe a common medical concern in layman's terms. Other component societies which stage similar legislative breakfasts represent the counties of Berrien, Genesee, Ingham, Jackson, Kalamazoo, Kent, Muskegon, Saginaw, Washtenaw and Wayne. Counties interested in establishing such a program may contact Kevin Kelly at MSMS headquarters.

The legislative topic at the OCMS breakfast was HB 5114, which would permit fully-licensed psychologists to sign certificates of hospitalization for involuntary mental patients. Among the six legislators at the breakfast was State Rep. James E. Defebaugh (R-65th District), center. Discussing the bill was Troy psychiatrist Harvey M. Halberstadt, MD, right.

At the March 15 breakfast at the Southfield Ramada Inn, State Rep. Douglas Cruce (R-71st District), right, chatted with Doctor Minkow.

ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine

Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

1 tablet b.i.d.

SUPPLIED

Bottles of 100 and 1000 scored 50 mg. tablets.

References:
1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: May 17-21, Advances in Internal Medicine. Location: Towsley Center for continuing Medical Education, University of Michigan. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **Cost:** $425. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 33.5 hours of Category I Credit.

Date: May 28-28, Biologic and Synthetic Vascular Prostheses. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** U-M Medical School Dept. of Surgery and the Office of Continuing Medical Education. **Cost:** $375, or $185 per day. **Contact:** Office of Continuing Medical Education, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, University of Michigan, Ann Arbor 48109, (313) 764-2287. **Approved for:** 14.75 hours of Category I Credit.

Date: June 2-4, Current Topics in Blood Banking. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Office of Continuing Medical Education and Health Professions Education, University of Michigan. **Cost:** $175. **Contact:** Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 9 hours of Category I Credit. An additional 3-4 credit hours are available for participation in selected Preconference Workshops June 2.

Date: June 3 and 4, Prevention of Hereditary Large Bowel Cancer. Location: Westin Hotel, Detroit. **Sponsors:** Comprehensive Cancer Center of Metropolitan Detroit, Michigan Cancer Foundation, American Cancer Society, and National Large Bowel Cancer Project. **Cost:** $150. **Contact:** Bruce Deighton, (313) 577-1848. **Approved for:** 10 hours of Category I Credit.

Date: June 9, Medical Update in Family Practice, "The Geriatric Patient". Location: Saint John Hospital, Detroit. **Sponsor:** Continuing Medical Education Committee of Saint John Hospital. **For (specialty):** all interested Family Physicians. **Contact:** Linda Campbell (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 7-11, A Postgraduate Institute for Career Emergency Physicians. Location: Detroit Receiving Hospital, 4201 St. Antoine in the Detroit Medical Center. **Sponsors:** Wayne State University School of Medicine Section of Emergency Medicine and American College of Emergency Physicians. **For:** Emergency medicine specialists. **Contact:** Gerald Prieur, Division of Continuing Medical Education, WSU School of Medicine (313) 577-1180. **Approved for:** 35 hours of Category I Credit.

Date: June 9-11, Hematology: Clinical and Laboratory Update. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Division of Hematology-Oncology, the Simpson Memorial Institute, and the Department of Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $250, or $90 per day. **Contact:** Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, University of Michigan, Ann Arbor 48109 (313) 764-2287. **Approved for:** 19.25 hours of Category I Credit.

Date: June 14-18, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine, and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 18, 1982, Child Abuse and Neglect: The Hospital Team Approach. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M De-

Continued on page 282

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Studies have confirmed the following applications for the Entero-Test:

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Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include Giardia lamblia (motile trophozoites), Strongyloides stercoralis (larvae and/or eggs in advanced stages of development), Clonorchis sinensis (eggs), Fasciola hepatica (eggs), Trichostrongylus orientalis (eggs), and Isospora (coccidia).

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Multiple stool exams cultured over several weeks or duodenal intubation are the most commonly used procedures. The Entero-Test is as efficient as intubation but simpler and more comfortable. New studies have further confirmed superior applicability over other procedures.

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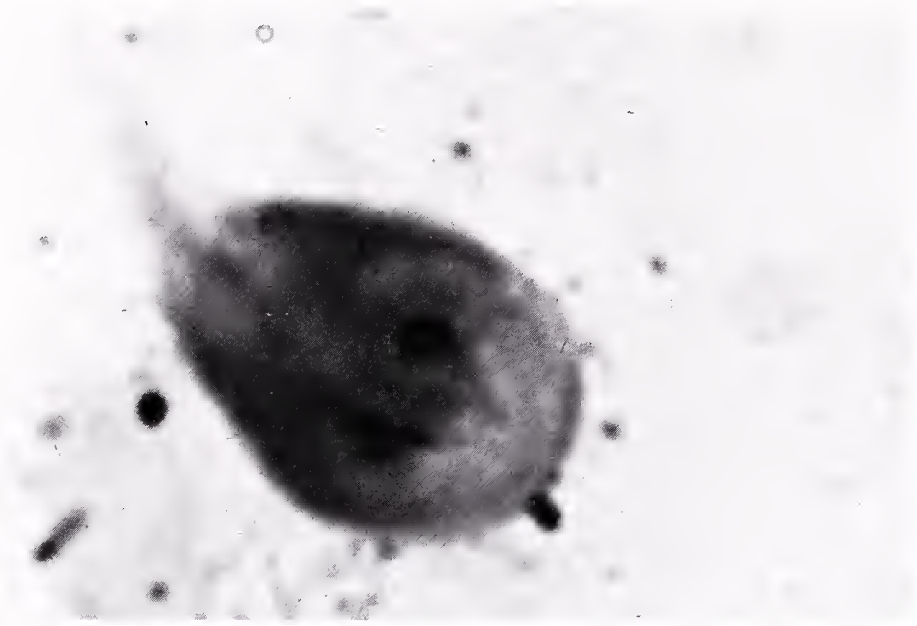

Giardia lamblia

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2. Beal, CB., *et al.*, A New Technique for Sampling Duodenal Contents, Am. J. Trop. Med. & Hyg. 19:349, 1970.
3. Bezjak, B.: Evaluation of a New Technique for Sampling Duodenal Contents in Parasitologic Diagnosis, Am J Dig Dis 17:845, 1972.
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11. Baron J.H: The clinical use of gastric function tests. Scand. J. Gastroent. Suppl. 6:9, 1970.
12. Rosenthal, P., Liebman, W.M: Comparative Study of Stool Examinations, Duodenal Aspiration, and Pediatric Entero-Test for Giardiasis in Children. J. Pediatr. 96:278, 1980.
13. Liebman, W.M., Rosenthal, P: The string test for gastroesophageal reflux. Am. J. Dis. Child 134:775, 1980.

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CATEGORY I/*continued*

partment of Postgraduate Medicine and Health Professions Education. **Cost:** $95. **Contact:** Office of Continuing Medical Education, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 7.75 hours of Category I Credit.

Date: June 18-20, 33rd Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University Department of Surgery. **Contact:** B. E. Henig, MD, Keyport Clinic, P.O. Box 605, Grayling 49738 (517) 348-6611. **Approved for:** 12 hours of Category I Credit.

Date: June 20-25, 18th Annual Northern Michigan Summer Conference. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** Dept. of Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $335, or $90 per day. **Contact:** Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, University of Michigan, Ann Arbor 48109 (313) 764-2287. **Approved for:** 20 hours of Category I Credit.

Date: July 7-8, Wayne State University Symposium on Cerebral Resuscitation. Location: Westin Hotel, Detroit. **Sponsor:** Wayne State University School of Medicine. **Contact:** Gerald Prieur, Division of Continuing Medical Education, (313) 577-1180. **Approved for:** 12 hours of Category I Credit.

Date: July 22-25, Fourteenth Annual Summer Conference — Update for General Practice Ophthalmologists. Location: Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Cost:** $150. **Contact:** Leslie E. Meissner, MOS Administrative Assistant, (313) 839-3011. **Approved for:** 8 hours of Category I Credit.

Date: July 22-26, Intermediate Course on Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: July 29-30, Sixty-Second Annual Coller Penberthy Thirlby Medical Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center Continuing Education. **Cost:** $50. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, Traverse City 49684 (616) 947-6140, Ext. 146. **Approved for:** 9 hours of Category I Credit.

Date: July 30-Aug. 1, Arrhythmias and Cardiac Ischemia: Diagnosis and Management. Location: Boyne Mountain Resort, Boyne City. **Sponsor:** International Medical Education Corporation. **For:** Physicians, nurses and technicians. **Cost:** Physicians — $245, Nurses and technicians — $130. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, 64 Inverness Drive East, Englewood, CO 80112 (303) 773-1144 or 800-525-8646. **Approved for:** 13 hours of Category I Credit.

Date: Aug. 23-27, Tutorial on Direct Action Thrusting. Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: September 9-11, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, Chairman, 290 Blodgett Professional Building, 1900 Wealthy St., SE, Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Sept. 10, "Seventh Annual Cardiac Rehabilitation and Exercise Testing Symposium." Location: Borgess Medical Center, 1521 Gull Road, Kalamazoo. **Sponsor:** Borgess Medical Center/Southwestern Michigan Area Health Education Center. **Cost:** $65. **Contact:** Laura Denman, MS, Cardiac Rehabilitation Institute, Borgess Medical Center, Kalamazoo, 49001 (616) 383-8342. **Approved for:** 7 hours of Category I Credit.

Date: September 10-12, Fifth Annual Court in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Department of Radiology and Department of Postgraduate Medicine and Health Professions Education, The University of Michigan Medical School. **For:** all interested physicians. **Cost:** $275. **Contact:** David Bruce Youel, MD, Director, Office of Continuing Medical Education, Towsley Center, U-M Medical Center, Ann Arbor 48109 (313) 763-1423. **Approved for:** 16 hours of Category I Credit.

Date: September 24-26, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Oct. 14-17, Annual Regional Meeting of the Michigan Chapter, American College of Physicians. Location: Traverse City Hilton. **Sponsor:** American College of Physicians. in association with the Michigan Society of Internal Medicine. **Contact:** Arnold R. Axelrod, MD, Sinai Hospital of Detroit, (313) 493-5780. **Approved for:** 25 hours of Category I Credit.

Date: October 15-16, Cardiac Rehabilitation. Location: Hyatt Regency Dearborn. **Sponsor:** International Medical Education Corporation. **Cost:** $245. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive East, Englewood, CO 80112 800-525-8651 or 303-740-8445, ext. 123. **Approved for:** 13 hours of Category I Credit.

Date: Oct. 25-29, Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of category I Credit.

Date: Nov. 1-5, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Kellogg Center, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Nov. 8-10. Manual Medicine to the Extremities. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Dec. 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Here's how MSMS dues compare with other state health organizations

Association	Dues			
	State	National	Local	Total (range)
Michigan Nurses	$140	$55	$5-$25	$200-$220
Michigan Podiatry	$775	$375	$35	$1,185, plus a $1,000 assessment over next two years.
Michigan Dental	$260	$200	$25-105	$485-$565, plus $50 mandatory Assessment
Michigan Optometric	$395	$300	$25-125	$720-$820
Michigan Chiropractic Plus $100 Fraternal Order which provides professional liability insurance eligibility	$400 (after 5 years)			$500
Michigan Assoc. of Osteopathic Physicians & Surgeons (After 3rd year), plus $100 for osteopathic college of choice, plus $100 for MSU College of Osteopathic Medicine	$325			$525
MAOPS also requires a $25 per year building fund assessment for the first five years of membership				
And in comparison: MSMS	$260	$285	$25-$160	$570-$705

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Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of child-bearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References
1. Data on file, Medical Department, Pennwalt Pharmaceutical Division.
2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York, Stratton Intercontinental, 1976, pp 221–245.
3. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318–321, 1974.
4. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843–848, 1971.
5. Winchester JF, Kellett RJ, Boddy K, et al: Metolazone and bendroflumethiazide in hypertension: Physiologic and metabolic observations. *Clinical Pharmacol Ther* 28:611–618, 1980.
6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527–533, 1975.
7. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745–750, 1976.
8. *Drug Topics Red Book*, 1982.

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MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

June 12-13 — Medical Assistants Midwest Regional Meeting, Weber's Inn, Ann Arbor, contact: Caroline Rich, MSMS headquarters.

June 13-17 — Annual Meeting, American Medical Association, Chicago, contact: AMA, 535 N. Dearborn, Chicago 60610 (312/751-6000).

June 13-16 — AMAA Convention, Drake Hotel, Chicago, contact: Caroline Rich, MSMS headquarters.

June 30 — MSMS/INTRAV Rhine River Adventure (14 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

July 11-14 — The Council Midsummer Session, Grand Traverse Hilton, contact: Warren F. Tryloff, MSMS headquarters, 517/337-1351.

July 17-18 — Medical Assistants Summer Seminar, Spring Lake Holiday Inn, Spring Lake, contact: Caroline Rich, MSMS headquarters.

July 18 — MSMS/INTRAV Alpine Adventure (15 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

Oct. 28 — MSMS Leadership/Public Affairs Conference, Long's Convention Center, Lansing, contact: Bill Madigan or Kevin Kelly at MSMS headquarters.

Nov. 9-10-11 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

Other meetings

April 15-16 — Nursing Standards Seminar, Grand Rapids, contact: Julie Efaw, Joint Commission for the Accreditation of Hospitals Headquarters.

April 24-25 — Stress Management Conference, sponsored by Seminars for Effective, Extended Knowledge, Book Cadillac Hotel, Detroit, contact: Dee Chrisler (313/238-1196).

May 5 — Childrens Hospital of Michigan William Evans Memorial Lecture "Psycho-social, Ethical and Legal Issues in Genetic Medicine," Detroit, contact CHM Community Relations, (313/494-5373).

May 5-6 — Childrens Hospital of Michigan Annual Clinic Days, "Disorders of Genetic Origin," Detroit, contact, CHM Community Relations (313/494-5373).

May 5-7 — Annual Meeting and Scientific Session, Michigan Chapter, American College of Surgeons, Grand Plaza Hotel, Grand Rapids, contact: Viola Heins, 517/337-1351.

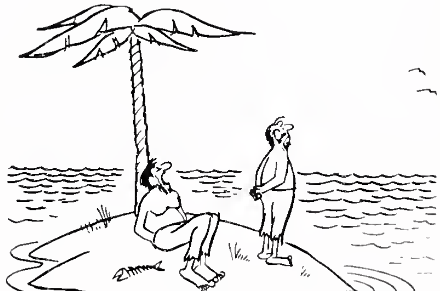
May 7 — Annual Meeting of the Michigan Society of Thoracic Surgeons, Amway Convention Center, Grand Rapids, contact: Rodman E. Taber, MD, Secretary, Michigan Society of Thoracic Surgeons, Wayne County Medical Society, 1010 Antietam, Detroit 48207.

May 17 — Orthopaedic Clinic Day, Childrens Hospital of Michigan, Detroit, contact CHM Community Relations (313/494-5373).

May 20-22 — Michigan Association of Osteopathic Physicians and Surgeons, 83rd Postgraduate Conference and Scientific Seminar, Westin Hotel, Detroit, contact: D.A. Deshaw, Executive Director, Michigan Association of Osteopathic Physicians and Surgeons, 33100 Freedom Road, Farmington 48024, 313/426-2300.

June 1-3 — "A Look at Local Public Health in Michigan," Michigan Public Health Association, contact: MPHA, 1407 S. Harrison Road, Suite 340, East Lansing 48823.

June 3 — American Medical Women's Association, Inc. meeting, Mother Lode Restaurant, 3411 E. Michigan, Lansing, contact: Suzanne Sorkin, MD, 372-2898.



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Cost-containment training can reduce medical costs

By Deborah Zannoth
East Lansing

A recent report from the US General Accounting Office discusses cost-containment programs in medical schools and their effects on medical care costs.

Research studies have shown that physicians are often unaware of the cost of medical services they order and that cost-containment training can result in their practicing more cost effective medicine through shorter hospital stays, fewer laboratory tests and less frequent follow-up visits. The knowledge, skills and attitudes acquired through educational experiences are principal determinants of the way physicians will practice medicine throughout their careers.

In late 1980 questionnaires were mailed to the deans of all 126 medical schools in the US and its territories. The questionnaire was designed to determine the number of medical schools providing cost-containment, the number of students who received this training and the effects of the training; e.g., dollar savings, increased physician productivity.

Seventy-seven percent (90) of the 117 medical schools responding said that they were providing cost-containment training to their students. Sixty-eight percent of their 1981 graduates received such training compared to 60 percent of the graduates in 1979.

The cost-containment training varied widely in approach, content and emphasis. Forty-one percent used a structured approach planned in advance as part of the curriculum. Fifty-nine percent taught cost-containment as the need arose.

Some schools taught cost-containment from the standpoint of general economics surrounding medical practice and included instruction in such subjects as sources of health care funds, factors influencing increases in costs, the role of health planning and the nature of utilization review. Other schools have integrated cost-containment principles into medical practice courses.

The report concluded that physicians' knowledge of cost-containment principles is an important element in the nation's efforts to control health care costs. Medical schools and residency programs have been leaders in efforts to increase physicians' sensitivity during their formative years to cost effectiveness as an important aspect of medical practice.

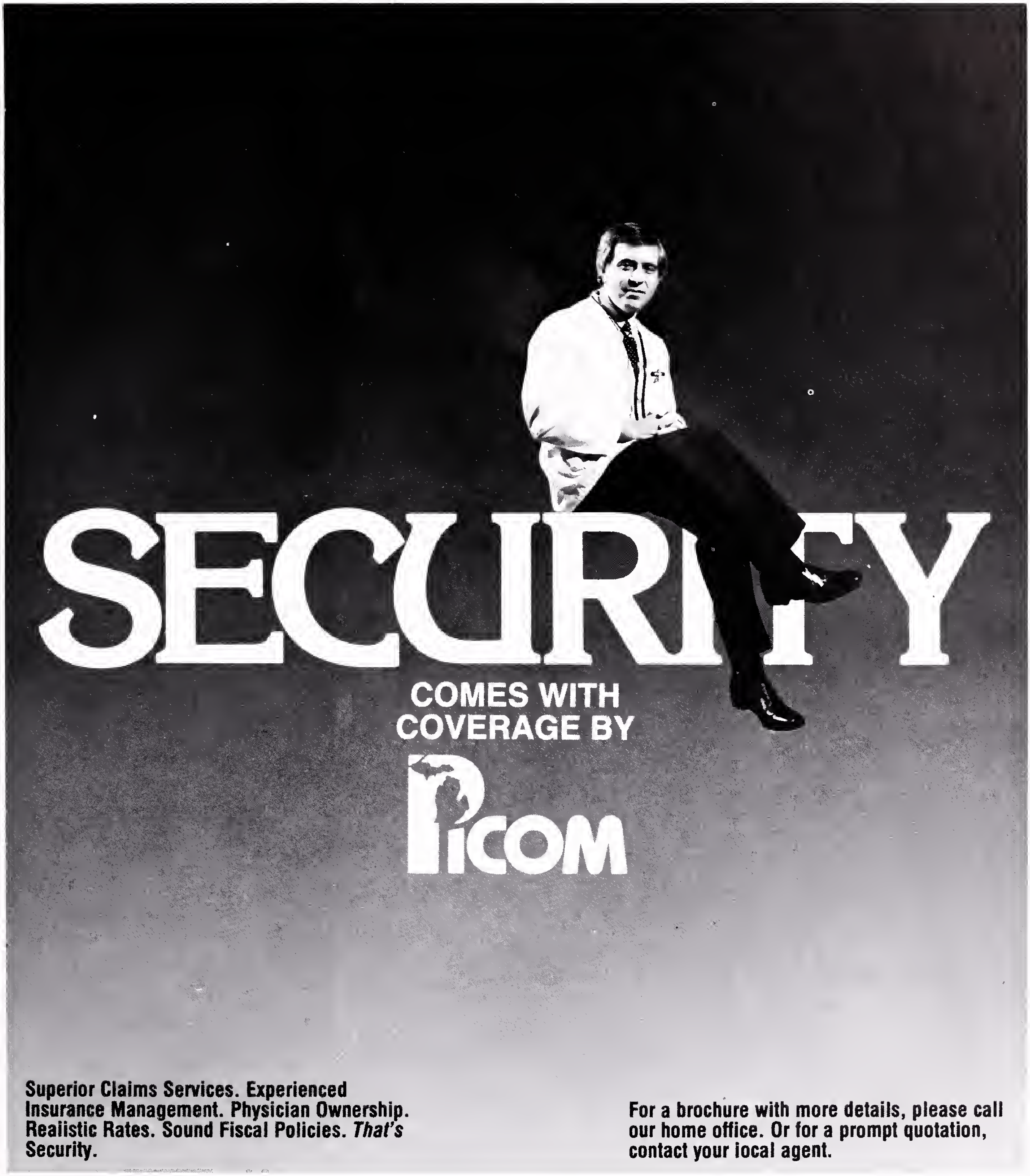
The ultimate success of physician cost-containment training depends largely on the commitment of faculty members to such training. The GAO believes, however, that the federal government should monitor the medical professions cost-containment training efforts and selectively fund conferences and seminars dealing with methods for teaching cost-effective medicine.

The GAO recommended that the Secretary of Health and Human Services should do the monitoring as well as provide funding for seminars and conferences for medical school faculty on a carefully selected basis.

Copies of the complete report are available from the following address:

US General Accounting Office
Document Handling and Information Services Facility
P.O. Box 6015
Gaithersburg, MD 20760

Ms. Zannoth is assistant to the MSMS Bureau of Economics.



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DEATHS

George H. Agnew, MD
Midland

George H. Agnew, MD, Midland, died Dec. 16. He was 79. Doctor Agnew graduated from the University of Western Ontario School of Medicine in 1928. A semi-retired obstetrician/gynecologist, Doctor Agnew was affiliated with Harper, Hutzel and Doctors Hospitals over the span of his more than 50-year career.

Richard L. Bakken, MD
Battle Creek

Richard L. Bakken, MD, Battle Creek, died February 10 at the age of 58. Doctor Bakken received his medical degree in 1949 from the University of Oklahoma, then interned at Percy Jones Hospital, Battle Creek. After several years of private practice in Oklahoma and two years as a military surgeon in Korea, Doctor Bakken returned to Battle Creek, where he was affiliated with Community Hospital, Leila Y. Post Montgomery Hospital, and Sanitarium Hospital.

Norbert L. Bielat, DO
Kalamazoo

Norbert L. Bielat, DO, Kalamazoo, died February 4. He was 50. Doctor Bielat earned his DO degree at Kirksville Medical School in 1964. He had served in the Army Medical Corps from 1951 until 1954, and had been affiliated with the Western Michigan University Health Center at the time of his death. Doctor Bielat was a member of the American Osteopathic Association, the Michigan Association of Osteopathic Physicians and Surgeons, the American College of General Practitioners, and the Michigan Association of Osteopathic General Practitioners.

Moses Cooperstock, MD
Marquette

Moses Cooperstock, MD, Marquette, died January 30 at the age of 81. Doctor Cooperstock earned his medical degree in 1926 from Yale, and was elected to Phi Beta Kappa. He was an instructor of Pediatrics at the University of Michigan from 1928 to 1930, then moved to Marquette, where he helped establish the Michigan Children's Clinic. He served as Pediatric Medical Director at the clinic, which brought specialized pediatric care to the Upper Peninsula for the first time. In the 1940's, Doctor Cooperstock developed a center in Marquette for the care of children stricken with paralytic poliomyelitis. He entered private practice after devoting nine years to the clinic, and in 1962 became Marquette's health care officer. Doctor Cooperstock retired in 1975 after 50 years in medicine, and in 1978 was awarded the Northern Michigan University President's Award for Distinguished Citizenship. He served organized medicine as a former president of the Marquette-Alger County Medical Society.

James P. Curran, MD
Hastings

James P. Curran, MD, Hastings, died February 17. He was 76. Doctor Curran

Continued on page 292

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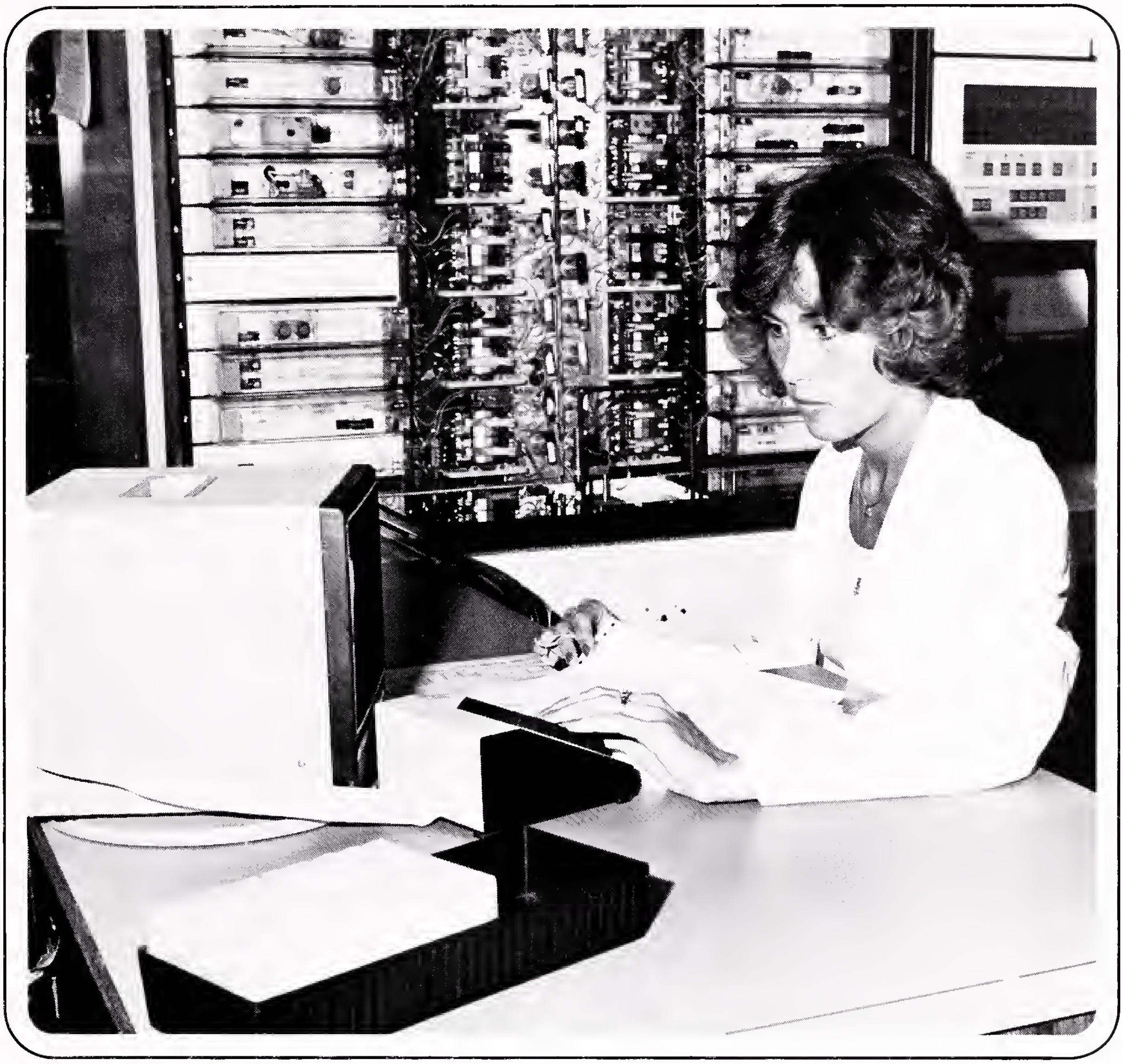

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received his MD from New York University, and served for four years as a medical officer with the First Air Corps in World War II. He maintained an anesthesiology practice in Dayton, Ohio for 30 years before moving to Kalamazoo, where he directed the Gerentology Program at Kalamazoo State Hospital. Doctor Curran retired to Hastings in 1972.

John J. Danielski, MD
Livonia

John J. Danielski, MD, Livonia ophthalmologist, died Dec. 9. He was 50. Doctor Danielski received his medical degree from Wayne State University in 1955, and had been affiliated with William Beaumont Hospital in Royal Oak. Doctor Danielski served in the Air Force Medical Corps from 1956 until 1958.

Robert E. Fisher, MD
Battle Creek

Robert E. Fisher, MD, Battle Creek, died Feburary 19 at the age of 71. Formerly Calhoun County Medical Examiner, Doctor Fisher earned his MD at Washington University of St. Louis, where he graduated cum laude in 1934. Because he graduated at the top of his class, he was named to Alpha Omega Alpha, and Sigma Xi fraternities. While pursuing his internal medicine specialty at Washington, Doctor Fisher assisted two doctors in Nobel prize-winning research. He served his internship and residency at Henry Ford Hospital, then joined the Army Medical Corps from 1941 until 1946. Doctor Fisher had been assistant to the administrator for the Michigan Crippled Children's Commission, and Secretary of the Michigan Heart Association. He was Medical Director of Provincial House until 1980.

Olga Sirola Foreman, MD
Ypsilanti

Olga Sirola Foreman, MD, Ypsilanti, died February 7 at the age of 71. Doctor Foreman was director of Snow Health Center at Eastern Michigan University for 25 years. She earned her medical degree at the University of California in 1935, and was active in Altrusa Service Club and Alpha Epsilon Iota medical fraternity.

Thomas Green, Jr., MD
Detroit

Thomas Green, Jr., MD, Detroit orthopedic surgeon, died February 13. He was 56. Doctor Green graduated from Meharry Medical College in Nashville in 1953, after earning his undergraduate degree at Wayne State University. His practice in Detroit spanned 20 years, and he was an active member of the Detroit Surgical Society.

John W. Hansen, MD
Clarkston

John W. Hansen, MD, Clarkston, died Nov. 25, at the age of 93. Doctor Hansen received his MD degree from Marquette University in 1915, and served as a first lieutenant in the Army Medical Corp in WWI until 1919. He attended post-graduate courses at Harvard Medical School, concentrating on urology and dermatology, before establishing his 50-year general practice.

Jesse F. Harrold, MD
East Lansing

Jessie F. Harrold, MD, East Lansing urologist, died Jan. 21. He was 73. Doctor Harrold received his medical degree from the University of Illinois Medical School in 1934. In 1937 he set up his Lansing practice which he maintained until his death. Former president of the Ingham County Medical Society, Doctor Harrold also was former chief of staff at St. Lawrence Hospital. He was the co-founder of the Western Michigan Urological Society, member of the American College of Surgeons, and Nu Sigma Nu Medical Fraternity.

Royal C. Hayden, Jr., MD
Oak Park

Royal C. Hayden, Jr., MD, Oak Park, died Dec. 20. He was 49. Doctor Hayden received his medical degree from the University of Minnesota in 1956, then served in the Army Medical Corps until 1959. Former chief of the Division of Otology and director of the Otological Research Lab at Henry Ford Hospital, Doctor Hayden was a member of the Detroit Otolaryngological Society and the American Board of Otolaryngology.

Continued on page 294

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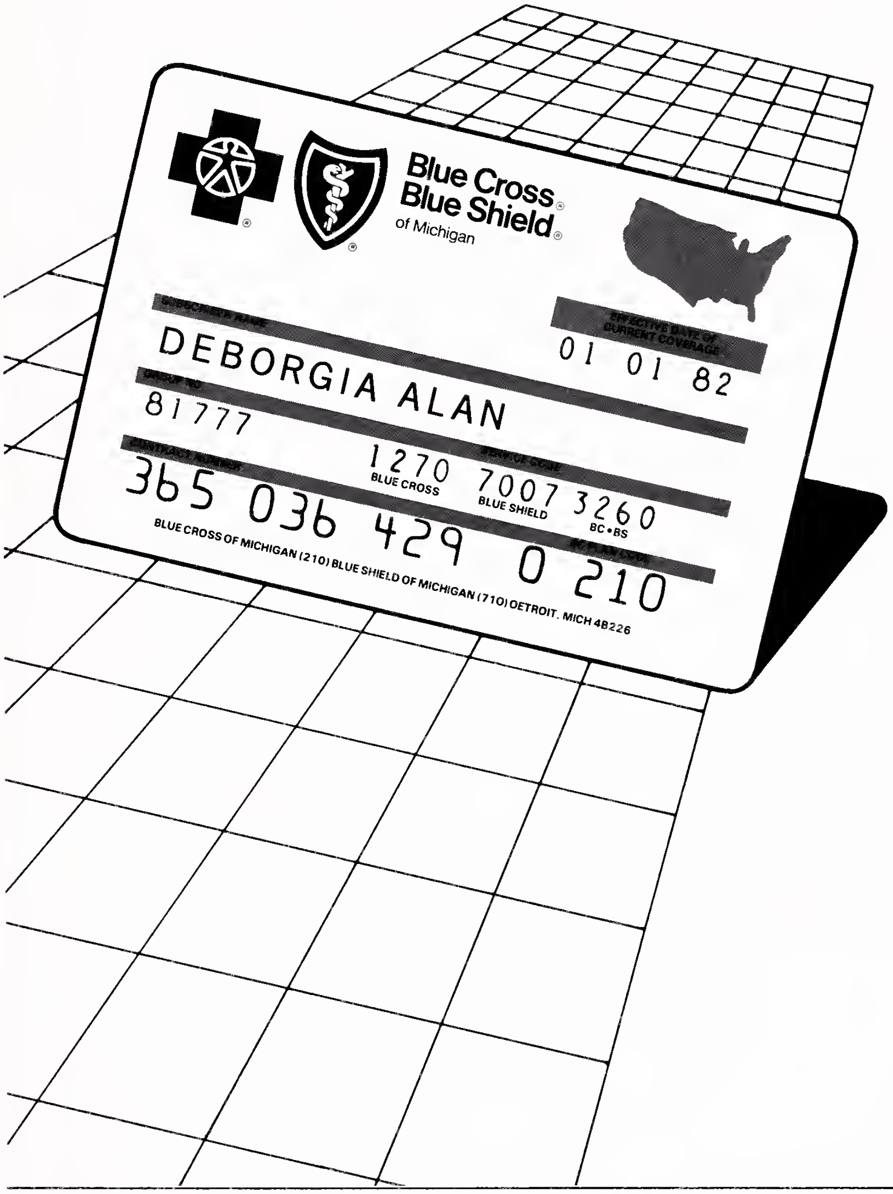
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Aben Hoekman, MD Ruskin, FL

Aben Hoekman, MD, formerly of Pontiac, died Dec. 8, at the age of 77. Doctor Hoekman graduated from the University of Michigan Medical School in 1931 where he studied anesthesiology. He served in the Army Medical Corps from 1942 until 1946. Doctor Hoekman was formerly president and secretary of the St. Joseph County Medical Society, and had been affiliated with Pontiac General Hospital.

Harry Y. Hoffman, MD Bloomfield Hills

Harry Y. Hoffman, MD, Bloomfield Hills, died January 26, at the age of 69. A general practitioner, Doctor Hoffman received his MD from Wayne State University in 1938, and served as Lieutenant Commander in the U.S. Navy in World War II. He served as Chief of Staff at North Detroit General Hospital, and made house calls throughout his 43-year family practice.

John L. Isbister, MD Okemos

John L. Isbister, MD, Okemos, died March 4 in Williamsburg, Virginia. He was 66. He received his medical degree from Wayne State University in 1943, where he specialized in Public Health Administration. He served at Valley Forge Hospital in Pennsylvania during his two-year Army duty, and later took up the study of environmental health even before such cases gained popular attention. Doctor Isbister was a staff physician for six years at Ingham Medical Center when it was a treatment center for tuberculosis patients, then in 1966 was named chief of the community health bureau. He became head of the disease control and lab services division of the Michigan Department of Public Health in 1975, and in 1981 retired as the department's state disease control officer. Doctor Isbister had served as secretary and bulletin editor of the Ingham County Medical Society, and was active in the Michigan Thoracic Society and the Michigan Chapter of the American College of Chest Physicians.

Siebe W. Kuipers, MD Holland

Siebe W. Kuipers, MD, Holland, died February 23 at the age of 63. He received his medical degree in 1945 from Wayne State University School of Medicine, where he specialized in internal medicine. He was affiliated with Holland City Hospital. Rotary Club, the Chamber of Commerce, and the American Legion were his civic interests, and in 1959 Doctor Kuipers served as the Ottawa County Medical Society's president. He was a veteran of medical military duty.

Isadore Lampe, MD, PhD Ann Arbor

Isadore Lampe, MD, PhD, Ann Arbor, died January 25. He was 75. Doctor Lampe, a pioneer in radiation therapy and professor emeritus at the University of Michigan, earned his medical degree from Case Western Medical Reserve in Cleveland. He received his PhD in roentgenology from the U-M in 1938, then began his 40-year

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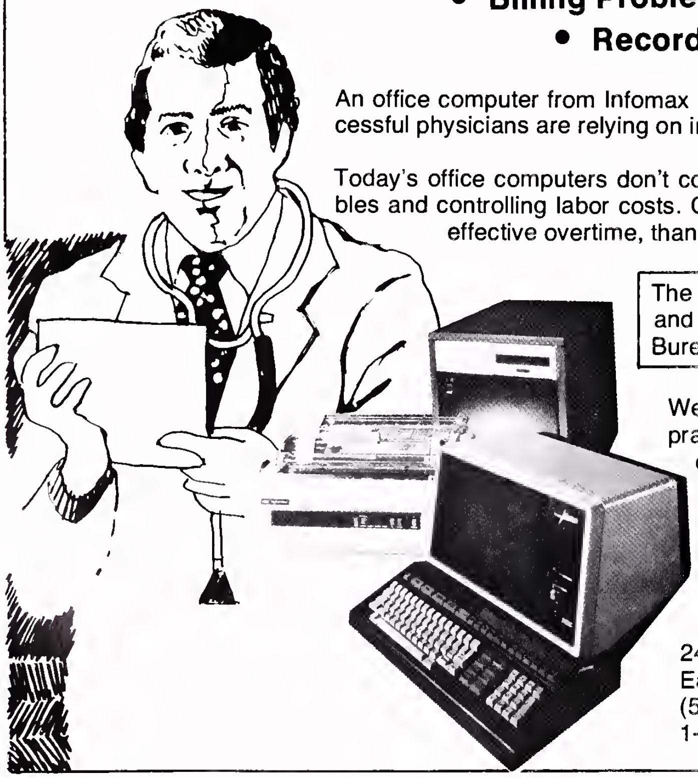

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career which was spent entirely at the University of Michigan. Doctor Lampe developed a special technique of X-ray therapy for gynecological tumors, and in 1979 was awarded the Gold Medal of the American Society of Therapeutic Radiologists. That same year, Doctor Lampe was recognized by the University of Michigan Medical Center Alumni Society for distinguished teaching and radiological research. He retired in 1974, and in 1981 an annual lectureship was established in his honor.

Kathryn Jean McMorrow, MD
Rochester

Kathryn Jean McMorrow, MD, Rochester, died February 2. She was 61. Doctor McMorrow earned her medical degree from the University of Buffalo School of Medicine in 1943. She was the only woman graduate in her class. Doctor McMorrow received a Master of Public Health degree in 1947, and was listed in Who's Who of America. She was an instructor at the Wayne State University School of Medicine's Neurology Department. Doctor McMorrow was a diplomat of the American Board of Physicial Medicine and Rehabilitation, and a Fellow of the American Public Health Association, and the Royal Society of Health, London, England.

Hazen Miller, MD
Petoskey

Hazen Miller, MD, Petoskey, died Dec. 22, at the age of 85. He received his MD degree from the U-M in 1920, and was a Fellow of the American College of Surgeons. Doctor Miller was a member of the American Urological Association and the Detroit Urological Society, and was a Diplomate of the American Board of Urology. As he was an avid conservationist and fisherman, the Hazen Miller Chapter of Trout Unlimited was named in his honor.

Robert J. Morrow, MD
Boca Raton, FL

Robert J. Morrow, MD, former Lansing proctologist, died Jan. 2 at the age of 80. Doctor Morrow graduated from the University of Alberta Medical School in 1925, and had been affiliated with Sparrow, St. Lawrence, and Ingham Medical hospitals during his career. He served in the military as a medical officer from 1942 until 1945, and was a Fellow of the American Proctological Society. He was formerly the president of the Michigan Proctological Society.

Frederick E. Sanocki, MD
Flint

Frederick E. Sanocki, MD, Flint general practitioner, died Nov. 30. He was 51. Doctor Sanocki received his MD degree from the University of Michigan Medical School in 1955, and was affiliated with St. Joseph, Hurley and McLaren hospitals of Flint. He was an active member of the Urban League and the National Association for the Advancement of Colored People (NAACP), and a member of Phi Chi Medical Fraternity.

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Physicians may have to offer more for less to compete

By Judith Marr
East Lansing

Physicians, like Avis, are going to have to try harder.

In this age of physician surpluses, competition for health care dollars and increased expectations for longevity and technology, physicians are going to have to work for business as any other entrepreneur does. They may have to offer more for less.

That was the message from economist and writer Harry Schwartz, PhD, New York, to 150 members and guests at the March meeting of the Kalamazoo Academy of Medicine. Doctor Schwartz is a retired member of the *New York Times* editorial board and author of 18 books, including "The Case for American Medicine."

Doctor Schwartz, now writer in residence with the American College of Physicians and Surgeons, Columbia University, discussed the future of medicine at the Academy meeting Special guests included Kalamazoo hospital administrators and Western Michigan University health care faculty. Local news media covered the event.

Won't do as well

"I would guess 10 years from now most physicians won't do as well as now, proportionately to other populations," was Doctor Schwartz's rather disheartening prediction.

"There will be a great deal of eocnomic pressure on you doctors — from government, to hold down fees; from HMOs, from greater competition among yourselves," he said.

"The great ultimate battle," he said, "will be between hospitals and doctors over who controls the medical doctor. The key will be, who controls the patient?"

"This kind of competition is inevitable," he observed. "You are going to have to compete by quality of service and by price. Physicians no longer are a scarce commodity. All are going to have to suffer."

In his opinion, however, said Doctor Schwartz, a lot can be done on both sides if hospitals and doctors cooperate to see what can be done more economically.

"The great thing is that medicine has improved the lives of the U.S. people. It will continue to do so, but under severe economic restraints."

Doctor Schwartz described in personal terms the modern-day socio-economic dilemma our country faces regarding its superb medical care. He had earlier written of this dilemma in a February 8 *Newsweek* opinion piece entitled "We Need to Ration Medicine."

Doctor Schwartz said he spoke as a husband, son, father and brother of medical patients, and declared his opinion of U.S. medicine as the best in the world. His oldest son, he said, died two years ago of an astrocytoma. "Ten years ago," he said, "his life expectancy would have been just days. He lived three and a half years, and three of those years were good ones."

"One side of us wants these miracles," he said. "On the other hand, we don't want to pay the bill."

He cited "Powell's Law" of fundamental medical economics, named for the head of British national health care in the 1960s, which says that the potential demand for free medical care is infinite.

To most Americans, hospitalization seems free, due to our "almost national health insurance system." And we think, he said, "if it's free, why not the best?"

If we continue on our present path," he said, "we easily could be using 25 percent of the gross national product for medical care."

But he does not think we will, "because we want to do other things, too." And he does not think we should.

"We are going to have to find some way to keep the unlimited demand for medical care constrained to some level. One way or the other, the amount this nation spends on medical care probably will be capped at 10 percent of the GNP," he said.

Asked tough questions

He asked the tough questions of whether it's really society's obligation to use every surgical and medical possibility to keep some people "merely metabolizing."

"Do we really have to put everyone on kidney machines who needs it?"

During a question and answer period following his address, Doctor Schwartz express his personal dislike for health maintenance organizations. "The incentives are to give the patient as little as possible," he said.

As for the malpractice situation, he said he is "profoundly pessimistic."

"The potential revenues to be paid for malpractice are greater probably than physicians' combined incomes," he said. "The malpractice burden is beyond the financial capability of the medical profession to pay. It has to be paid by the public at large."

Leaving some of his audience shaking their heads in mock despair, Doctor Schwartz was challenged by the more upbeat closing remarks of Theodore Cooper, MD, Kalamazoo. But even Doctor Cooper, former HEW assistant secretary, long-time acquaintance of Doctor Schwartz and now Upjohn executive vice president, predicted that physicians "are going to be expected to do the same for less."

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Before prescribing, please consult complete product information, a summary of which follows:

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For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae.* To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

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For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

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Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

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1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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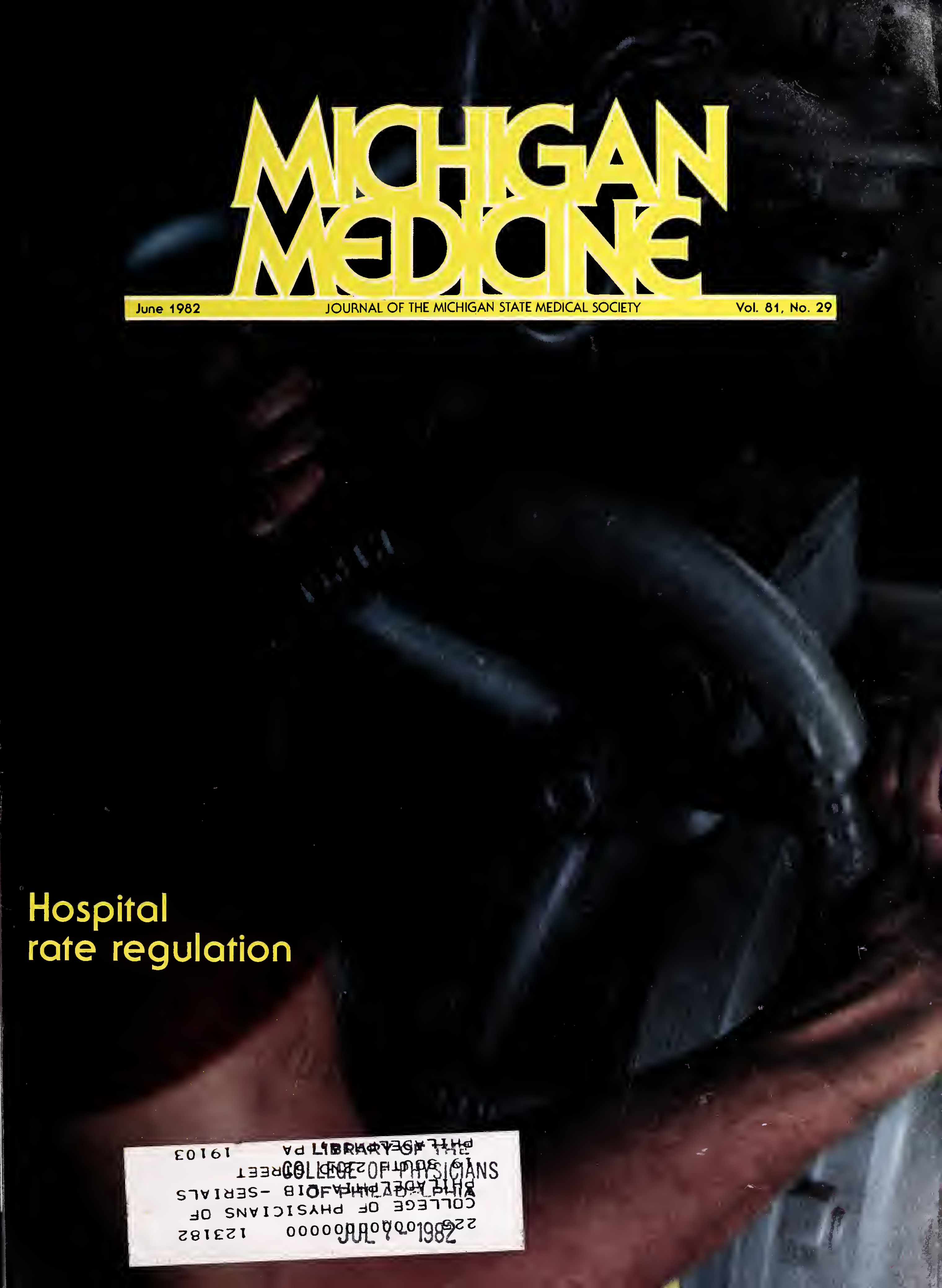
* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

MICHIGAN MEDICINE

June 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 81, No. 29



Hospital rate regulation

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MICHIGAN MEDICINE
Hospital rate regulation

Regulating the flow of health care dollars through the possible establishment of a hospital rate regulation commission is the subject of this month's cover story. **(Cover photo by Mert Scholten, MSMS staff).**

MICHIGAN MEDICINE

June 1982, Volume 81, No. 29

Special report

308 Hospital rate regulation: Would it be good for Michigan? The Governor is seeking legislation to establish a rate regulation commission, and there is much sentiment in the state for such a body. The pros and cons are plentiful, and *Michigan Medicine* attempts to sort them out for Michigan physicians through this issue. In addition, a report of the Maryland experience with a hospital rate regulation commission is summarized, for some interesting first-hand information; Kathleen Conway; Rhoda Powsner, MD

Features

318 In Memoriam: Oliver B. McGillicuddy, MD: Kenneth H. Johnson, MD

319 Meeting the challenge of the 80s, part III in a special MSMS series: Why not ask your patients how you're doing?

325 Time to begin planning for the 1982 MSMS Annual Scientific Meeting

326 Report on the MSMS Sports Medicine Conference; Kim Dean

332 Glucose screening during pregnancy helps reduce fetal mortality and morbidity; Elizabeth Jensen, RN, MED and Molly Graber, RD, MS

333 Maternal Health Desk Reference Card No. 11-14: Glucose intolerance during pregnancy

344 The physician as expert witness, part of a new MSMS and Michigan Bar Association Statement of Principles for Physicians and Lawyers

Departments

305 Letters

327 Meetings

328 Views; John R. Ylvisaker, MD

330 MSMS/A; Barbara Grennan

341 Category I courses

342 Board of Medicine actions

346 Deaths

354 Classified ads

355 Ad index

356 President's page; James H. Tisdel, MD

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Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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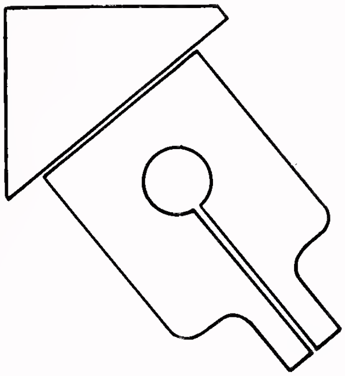
LETTERS



No identity crisis

Thank you for your April issue encouraging women physicians to integate into the medical power structure. It means a lot.

I was disappointed to read Doctor Rinke's comments that we attempt to reconcile our womanhood when faced with the aggression that it takes to get through medical school. I thought we had that worked through in the sixties.

In any case, I would really like to thank the Michigan Area X physicians in general and the Sturgis Hospital Medical Staff in particular for allowing me to be "assertive, ambitious, independent" and occasionally even "dominant" without worrying about an identity crisis — theirs or mine!

Sincerely,

Mary O. Anderson, MD
Board Chairperson
MAX-PSRO
Leonidas

Bill Burns

Congratulations on your article regarding Bill Burns. I well remember the first time I met him in July 1938.

The state officers, Burns, Foster, Claude Perry, etc., made a trip through the UP and as President of our County Society, I tried to show some appreciation for their trip. As a result, I found myself on the council '38 to '48 and AMA delegate '48 to '58. I blame Bill; and thank him for getting me involved in the organization, a very rewarding and I might add, expensive experience.

Very truly yours,

W. H. Huron, MD
Iron Mountain

Blues audits

A recent article in *Michigan Medicine* (February, 1982, pg. 126) questioned the authority of Blue Cross and Blue Shield of Michigan (BCBSM) to audit physicians' records of BCBSM subscribers. The article stated that "some Michigan physicians resent the practice as an invasion of their rights and the patients' protection of privilege." The article goes on to state that "some doctors believe that BCBSM does not have a right of audit because there is no Michigan law on the subject and because there is no contractual relation between physician and third party payers that grants such a right."

As the *Michigan Medicine* article has raised a number of issues regarding audits of physicians' medical records by BCBSM, our position on these issues is as follows:

The nature and scope of the audit

BCBSM conducts audits to determine its liability and to correct errors discovered during the course of the audit. As a general proposition, audits are done to determine if the service was rendered, medically necessary, appropriate for the patient's condition, a covered benefit and properly billed.

A US Federal District Court has supported this right asserted by BCBSM, by issuing an order stating that BCBSM has a right to audit the records of a pharmacy that services BCBSM subscribers.

Access to medical records

Subscribers have specifically authorized BCBSM to examine their hospital and medical records. The authority to examine such records is derived from three sources:

(1) the application for BCBSM coverage; (2) the subscriber identification card, and (3) BCBSM benefit certificates and riders.

In the application for BCBSM coverage, the applicant specifically agrees that "... BCBSM may examine any record of hospitalization or medical treatment of myself and family members and that hospitals, doctors and other providers of service may furnish such records and reports to BCBSM."

Additionally, the subscriber identification card expressly provides that "Acceptance or use of this card acknowledges .. (the subscriber's) consent to the examination by BCBSM of all medical, hospital, and other records pertaining to treatment rendered to the subscriber or members using this card."

BCBSM benefit certificates also provide that members authorize "... physicians, hospitals and other providers of service to furnish to BCBSM, upon its request, information relating to services to which the member is or may be entitled ... Physicians, hospitals, and other providers of services are thereby authorized to permit BCBSM to examine their records with respect to the services ..."

Continued on page 316

Candidates for nutritional therapy...

10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socioeconomic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]

Before prescribing, please consult complete product information, a summary of which follows:

Each Berocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

Contraindications: Hypersensitivity to any component.

Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.

Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

Adverse Reactions: Adverse reactions have been reported with specific vitamins and

5,000,000 hospital patients with infections.[4] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[3]

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.[5]

Berocca Plus
A balanced formula for prophylactic or therapeutic nutritional supplementation.

Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.
Dosage and Administration: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.
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THE MULTIVITAMIN/MINERAL FORMULATION

Pros and cons: Does Michigan need a hospital rate regulation commission?

By Kathleen Conway
Detroit

The issue

Containing hospital costs is an issue that grows ever more intense. Hospitals, coalitions, private physicians — just about everyone involved — attempts to develop plans to curb rising medical costs. In 1978, the state, the Michigan Hospital Association and Blue Cross Blue Shield of Michigan tried to do just that by implementing the nationally unique Prospective Reimbursement Program which places controls upon hospital budgets. Through this voluntary program, which is supported by the state's hospitals, individual hospital budgets can increase only within allowable limits. The hospital will incur losses if costs are not held within an established ceiling.

However, there is still considerable sentiment specifically within the state government, that the establishment of a state rate regulation commission is necessary to sharply curtail rising costs. Gov. William Milliken, in his recent State of the State address, said he would seek legislation to form a rate-setting commission which, he claimed, "would create a mechanism by which the state can directly limit increases in hospital costs."

Have rate regulation commissions proven to be effective in curbing rising hospital costs? If so, does Michigan need such a commission? If not, can hospital costs be regulated on a voluntary basis more effectively? Will quality of care suffer if such a rate regulation commission is effected in Michigan?

These are some of the facets of this issue.

Background

A recent study by the American Hospital Association (AHA) found that Michigan hospitals ranked third best in the nation in controlling rising hospital costs in 1980. Total state hospital expenses in 1980 rose 11.9 percent, while the average increase across the U.S. was 16.4 percent. Only Alaska at 10.6 percent and New York at 10.9 percent held costs better, according to the AHA annual survey of 5,800 hospitals nationwide.

State hospital officials say the favorable ranking can, in part, be credited to the voluntary Prospective Reimbursement Program begun in Michigan in 1977.

The Prospective Reimbursement system sought to make hospitals self-regulating and accountable to each other in overall containment of costs by placing voluntary controls upon hospital budgets. Through the voluntary program, which was initiated by and thus supported by the state's hospitals, individual hospital budgets can increase only within allowable limits, and hospitals incur monetary losses if costs are not held in check. This method of reimbursement is now used by Blue Cross Blue Shield of Michigan and the state Medicaid program. It determines Blue cross reimbursement and affects over $1 billion annually in hospital payments.

But there are a number of other factors contributing to the state's success in holding costs down. State hospitals, on their own and separate from the Prospective Reimbursement Program, are concerned about curtailing hospital costs. Nearly every state hospital has committees geared to this end. In addition, such innovations as the use of shared service arrangements among hospitals are direct efforts to avoid costly duplication of services and thus reduce costs.

However, despite the state's success at controlling costs voluntarily, Michigan still ranks among the most expensive states for medical care. In 1980, state hospitals took in $3.5 billion in revenues, according to the AHA survey. California led the nation at $8.8 billion, followed by New York at $7.5 billion and Illinois at $4.8 billion. Health care analysts blame the rising national costs on higher labor costs, a nationwide shortage of nurses, an increasing proportion of elderly patients and widespread insurance coverage.

The fact that Michigan still is one of the most expensive states in the country for medical care is cause for concern within the state government.

It is with that in mind that Gov. Milliken, in his 14th and final State of the State address in January, called for the establishment of a state rate regulation commission. Legislation for the rate-setting program would be drafted by the Office of Health and Medical Affairs (OHMA), the official state health planning agency, with assistance from the state departments of social services, public health and insurance.

For state rate regulation commission

National attention on rate regulation commissions increased in the fall of 1980 with the publication of a study in the *New England Journal of Medicine*. The study, authored by Brian Biles, Carl Schramm and J. Graham Atkinson, reported the hospital cost control experiences of six rate-setting states compared with the balance of the nation. The six states included in the study were: Connecticut, Maryland, Massachusetts, New York, New Jersey and Washington. The investigators reported that during the period 1976 to 1978, the av-

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Ms. Conway is a freelance writer.

erage annual percent increase in expense from the preceeding year was 11.2 percent in those six states, which compared favorably with the 14.3 percent increase registered for the balance of the nation during that same time period. This statistically significant difference led the authors to conclude that prospective mandatory rate-setting programs that cover most patients can effectively contain hospital expense increases.

In Michigan, the Office of Health and Medical Affairs (OHMA), under the Michigan Department of Labor, has been given authority to set medical payments rates under an executive order signed by Gov. Milliken recently.

As part of its function as the state's health agency, OHMA would oversee administrative duties of the rate-setting programs. The assumption of these duties is also part of the workmen's compensation legislation signed into law in December, 1981.

Government-sponsored rate regulation procedures in Michigan were given an added boost in December when it was announced that the state will set rates for the medical services component of the workmen's compensation program. The overall thrust of the reform legislation is to cut costs to the program to make Michigan more competitive with other states, and thus create more incentives for businesses to locate here. The bill would give the worker's disability compensation bureau authority to set maximum charges for medical services. The bill, Senate Bill (SB) 582 was passed quickly in the Senate over the objections of the Michigan Hospital Association (MHA) and MSMS.

According to Jay Endsley of the Office of Health and Medical Affairs, advocates for the rate regulation commission claim that the commission will save money and that, in the long run, rising hospital costs will slow considerably. The idea is that self-regulation or voluntary efforts, specifically by hospitals, are not enough and that more effective, mandatory procedures are needed. The quality of medical care, advocates say, will not be affected.

Says Endsley: Hospitals have not been affected by the state's depressed economy. Since 1978, hospital payments have increased by 80 percent. Michigan is especially important, as it has four of the 15 most expensive counties in the country for hospital care costs. Doctors need to look at the issue because they have not had a fee increase since 1978; but that's an issue physicians must confront themselves."

Against state rate regulation commission

In an article published in "Michigan Hospitals" in March, 1981, Victor Van De Moortel, of the MHA, pointed out Michigan's prospective reimbursement system as a means to curb costs compared favorably with the rate-regulated states.

Kenneth Raske, MHA's senior vice president, said recently that such a commission would be detrimental to the industry and to the public. The claim is that the private sector does a better job than regulators do at containing costs and that it is possible that accessibility to medical care and the quality of that care would suffer.

MSMS, at its House of Delegates meeting May 1, passed a resolution stating its strong objection to a rate regulation commission. Rate setting has not been shown to contain costs and the rate of increase in hospital costs in Michigan is no greater than in states where there is mandated rate setting.

The Delegates approved the establishment of a committee to determine strategy and tactics for the MSMS to fight the establishment of such a commission in Michigan.

The MSMS resolution was introduced by Rhoda Powsner, MD, Ann Arbor cardiologist (see related article, page 314). "I can't say definitively that there would be a decline in the quality of care," says Doctor Powsner. "We simply don't know because no one has really looked at that issue. But there's no question in my mind, that if rate regulation goes into effect, things will change."

Doctor Powsner feels that the small community hospital will be most affected by a rate regulation commission as it struggles to keep up. That, she says, will affect the availability of care.

"The problem I have with this is that I think the state agencies have not adequately studied the issue. I think it's a kind of 'knee jerk' response. The point is that more information is needed to determine if governmental regulation is the way to go."

Outcome

Considering the costs of health care today, it is obvious that attempts to curtail rising costs are vital. The use of voluntary, prospective reimbursement practices has been shown to be very helpful in Michigan, allowing the state to compare quite favorably with other states in containing medical costs.

However, Michigan continues to be one of the most expensive states in the country for health care. Government officials see that fact and are working rigorously to correct it. Gov. Milliken's proposal for a state rate regulation commission is, according to state officials, the method needed to contain costs.

The controversy continues as the hospital industry attempts to maintain a certain level of autonomy and avoid the complicated imposition of governmental regulations. MSMS hopes to delve into the issue more thoroughly and to oppose such imposition on the basis that it would not be any more effective than current voluntary regulation.

Ultimately, the winner in this controversy must be the consumer.

The Maryland experience:

Rate regulations hold costs down

What happens when a hospital rate regulation commission is established? How well does it work? How do various health care populations respond and react to it?

Some of these questions may be answered by the following excerpts from the sunset legislative review of the Maryland Health Services Cost Review Commission. The rate regulation commission has been in effect there since 1971.

For Michigan physicians' enlightenment, here are excerpts of what the sunset review reported: (With a special thanks to Warren Deschenaux of the Maryland Department of Fiscal Services.)

- The Commission was created in response to rising health care costs and threats to the solvency of some hospitals.

The Health Services Cost Review Commission was establishied in 1971. The Commission was established to address the problems of rising costs and hospital solvency. The problems which called the Commission into being are not unique to Maryland. Rather, they reflect national trends, which economists see as rooted in the system of health care financing in the United States. They note that providers lack market incentives to economize in the provision of services because many patients are insulated from the full cost of medical services by insurance. The consequence is unusual upward pressure on prices.

The problem of containing health costs is a matter of continuing relevance in Maryland. Seventy-five percent of respondents to the citizen's survey were of the opinion that the cost of hospital care in Maryland is too high. This impression is supported by data provided by the American Hospital Association showing that while the national average charged per equivalent admission in a community hospital was $1,831 in 1979, the average charge in Maryland was $2,047. Seventy-two percent of the citizens questioned felt that State government should do more to contain health costs.

Results of other surveys indicate hospital executives favor continuation of the Hospital Rate Regulation Program by a margin of 41 to 9. Opposition to state regulatory efforts comes from rank and file doctors. Forty-eight percent of respondents to a survey of doctors opposed the existing regulatory program. Thirty-eight percent favored it and 14 percent had no opinion. However, the executive director of the Medical and Chirurgical Faculty of Maryland has indicated in an interview that the faculty does not oppose continuation of the existing program.

The essence of the state regulatory program is the requirement that regulated institutions secure State approval of their rates before they may go into effect. Within the health care community, there is a continuing debate over, first, which types of institutions should be included in a state rate-setting program, and, second, which health care costs should be included in state established rates. Especially important in the case of this second issue is the question of whether the charges of hospital-based physicians should be subject to state control. These issues are discussed below.

- The Commission does not regulate rates for most nursing homes.

The Commission was originally charged with establishing rates for all hospitals and nursing homes in Maryland. Regulation of hospital rates was to begin in fiscal year 1975. Nursing home rates were to be set the following year.

The nursing home industry has consistently contended that Medicaid reimbursement rates are inadequate. The basic concern is that the reimbursement process does not recognize that individual patients require varying degrees of care. As the commission, by law, would have to consider the reasonable costs of the institution, rates established by this commission could be more favorable to nursing homes. Presently under study is a revised Medicaid Reimbursement System. This system is designed to recognize the varying levels of care different patients may require. The net fiscal effect of implementing this system is, at this point, unclear.

- The Commission would prefer to concentrate on rates for acute hospital care.

The commission has been reluctant to exercise its rate setting authority outside of the area of acute care hospitals. In its 1979 annual report, the commission noted that the need for regulation outside of acute hospital market, is limited. It also noted that its expertise was largely limited to the acute general hospital area. The commission requested legislation to limit its jurisdiction to the charges of acute general hospitals. This conclusion was reiterated in the commission's 1980 annual report.

- Commission jurisdiction over rates for services of hospital based physicians is in controversy.

Another issue related to the jurisdiction of the Commission concerns whether the Commission has authority to establish rates for services rendered by hospital based physicians. As a matter of statutory construction, the issue was decided by the Maryland Court of Appeals in April of 1981. The Court's decision in *Health Services Cost Review Commission v. Holy Cross Hospital of Silver Spring* (#43, September term, 1980) concluded three years of litigation to rule that the Commission could not regulate the professional fees of hospital-based cardiologists, radiologists, and pathologists, even where such fees are placed on hospital accounts and billed by hospitals.

The case turned on interpretation of Article 43, Section 568U of the Annotated Code. Among other things, this section gives the Commission powers necessary to "assure all purchasers of health care hospital services, that the total costs of the hospital are reasonably related to the total services offered by the hospital." At issue was whether the physician charges involved were legally part of the "total costs of the hospital." The physicians involved had a contractual arrangement with the hospital. The terms of the contract provided for the physicians to be compensated by receiving amounts equaling 85% of charges to patients for their services. Patients were billed by the hospital. Physician compensation was not, however, contingent on collection of those charges from patients. The risk of nonpayment was on the hospital, not the doctors.

Applying rules of statutory construction, the Court determined that the Commission had not established such an arrangement to be what the Legislature had intended as costs of the hospital when it created the Commission in 1971. The Court noted that two sessions of the General Assembly had passed since the initiation of the litigation. "Nevertheless," the Court wrote, "the General Assembly has not seen fit to change the statute. If it intends a different interpretation, it will no doubt say so by amending the law relative to the Commission's powers."

● The Holy Cross decision revised previous interpretations of Commission jurisdiction.

The decision changed the previous understanding of the Commission's jurisdiction in the area of physician compensation. At the time of the Holy Cross decision, it was accepted that the Commission could establish rates for physicians (like radiologists and pathologists) who were retained either on a salary or a contractual basis. In the course of the Holy Cross litigation, the Commission attempted to establish that it had the authority to regulate such physicians irrespective of the method of compensation. This would have permitted the Commission to set rates for fee-for-service physicians as well. The result of the litigation, however, was to further limit the Commission's jurisdiction. As interpreted by the Commission, the Holy Cross case prohibits the Commission from establishing rates for services rendered by hospital-based physicians who are not salaried. Only charges for services rendered by salaried physicians are subject to regulation.

The effect of the Holy Cross decision is to remove from Commission jurisdiction charges related to professional services administered on a contractual basis. Both hospital executives and physicians were asked what they expected the effect of the Holy Cross ruling to be on patient charges in the future. Forty-two percent of hospital executives reported that they expected the decision to result in higher costs to patients, while 58 percent expected costs to be unaffected. Rank and file physicians tended to agree. Thirty-eight percent of respondents to a survey of physicians felt higher total charges to patients would result. Forty-nine percent anticipated no difference in charges, and 13 percent looked for lower total charges as a consequence of the decision.

Hospital executives expressed some discomfort with the result of the decision. Forty-five percent of survey respondents expressed the opinion that the Commission should be allowed to regulate the charges of hospital-based physicians. (Thirty-nine percent opposed such jurisdiction, and 16 percent had no opinion.)

Physicians were of another mind, however. Only 22 percent of physicians responding felt the Commission should be allowed to set charges with hospital-based specialists. The remainder (78 percent) felt specialists should set their own charges.

In an interview, the Executive Director of the Medical and Chirurgical faculty reported that the faculty had not opposed legislation in a previous session extending Commission jurisdiction to all physician charges passing through the hospital accounting system. He opposed regulation of all hospital-based physician charges, stating that such a requirement would discourage qualified specialists from practicing in Maryland hospitals.

● The Commission has proposed deregulation of all physician charges.

The Commission has responded to the decision with the regulatory equivalent of casting its hands in the air in despair. It has proposed a regulation which says, in effect, that if the Commission cannot regulate the charges of all hospital-based physicians, it will choose to regulate none of them. The regulation would exclude from Commission rates the costs of all physician services, including those presently on salary. This regulation was proposed in July and is scheduled for hearing in October.

The reasoning underlying the proposal is this: under the existing physician compensation arrangements, the physician can choose, by establishing a particular basis of compensation, whether charges for his or her professional services are to be subject to the jurisdiction of the Commission. It is the hypothesis of the Commission that physicians will choose that basis of compensation most likely to maximize their income. Physicians will prefer compensation within the jurisdiction with the Commission only when it provides more income than the alternatives. The result of this, from the Commission's point of view, is that the possibility of Commission-established rates for such services may work to assure the public the highest, rather than the lowest, possible charges.

The regulatory program was established to address the problems of rising health costs and solvency. There is evidence the program has been effective in meeting both objectives.

● Financial condition of Maryland hospitals has improved under Commission rates.

Hospital solvency was an important consideration in the establishment of the regulatory program. Bad debts put particular strain on these hospitals. Under the methodology established by the Commission, bad debts are considered a cost of the hospital. These costs are therefore includable in rates. Since the law provides that rates may not unduly discriminate against different classes of payers, all payers assume a share of the hospital's bad debt allowance. Previously, neither Blue Cross, Medicaid, nor Medicare allowed bad debts to be considered in their payment systems.

Hospital executives report inclusion of bad debt in rates has improved hospital revenues. Twenty-seven percent of respondents to the Executive Survey reported significant improvements in revenues, while 43 percent reported slight improvement. Thirty-one percent indicated inclusion of bad debts in rates had no affect on their hospital. Executives of urban hospitals were those most likely to see significant improvement.

- There is evidence prospective rate-setting has curtailed the growth of hospital charges.

The effectiveness of prospective rate setting programs has been a matter of considerable scholarly debate. The results of early studies cast doubt on the effectiveness of State rate setting programs. More recent research, however, indicates that as State rate setting programs have matured, they have had a discernible impact on hospital costs. Biles, Schramm, and Atkinson compared the rate of growth in expense per equivalent admission in six states (including Maryland) with mature and mandatory prospective rate setting programs to those in states without such programs. Using data for the period between 1970 and 1978, they show statistically significant differences in rates of growth between rate setting and non-rate setting states for the years 1976, 1977, and 1978.

Cost per admission in the five years before implementation of the program (1970-74) rose roughly 53 percent in Maryland, a rate 8 percent higher than that in the United States as a whole. This situation appears reversed in the five years since the program was implemented. While cost per equivalent admission rose nearly 69 percent between 1975 and 1979, Maryland's cost rose 47 percent. These data suggest the program has curtailed the rate of growth in cost per admission. Similarly, cost per day in Maryland grew at nearly twice the national rate between 1970 and 1974. In the subsequent five years the rate of growth was below that of the nation overall.

The impressions of hospital executives confirm these conclusions. Eighty-two percent of executives responding to the survey felt that the presence of the Commission had been very effective or somewhat effective in limiting the growth of patient cost per admission in their hospitals. Eighty percent indicated that the presence of the Commission had been at least somewhat affective in limiting the growth of patient cost per patient day. Executives also reported that this result has been achieved without adversely affecting quality of service. Ninety-eight percent rate the overall quality of Maryland hospital care as "excellent" or "good." Fifty-five percent reported quality of care had improved since rate regulation began. Only 12 percent reported a decline in quality.

- Measures of performance have important implications for the program and the State. The waiver of Medicaid and Medicare reimbursement regulations is hinged on Commission performance. The amount of Federal Medicaid assistance is also affected by performance measures.

The principal benefit of an effective rate setting program is obvious: the rate of growth in health care costs is curtailed. This means that citizens making payments to hospitals directly, to private insurers, or to the State for support of the Medicaid program pay less than they otherwise would have to. However, a program which can be statistically shown to be effective is important for some less obvious reasons too.

A key facet of the regulatory program itself is also geared to performance. The Commission establishes the rates charged to all payers for hospital services. This includes the state Medicaid program and the federal Medicare program. Payments to Medicaid and Medicare are made pursuant to a "waiver" of those programs' normal payment methods. Existence of the waiver is important to the Maryland program because certain hospital costs (especially bad debt) which are not reimbursable through those federally assisted programs, are included in commission rates. A continuation of the waiver, however, is subject to an agreement between the state and federal government imposing a cap on what federal payments will be. If Federal payments exceed that allowed in the cap, standard principles of reimbursement will be reapplied. This would seriously undermine the integrity of the overall regulatory program.

- Effective operation of the rate setting program depends on the good will of regulated hospitals.

As the statute is written, rate proceedings may be initiated by either the commission or regulated hospitals. If the proceeding is started by a hospital, the commission must act within 150 days or else the rate application is automatically approved.

The commission establishes rates for 63 hospital units. If any substantial number of these units choose to submit applications for revised rates at the same time, there is a wide concensus that the organization would be ill equipped to thoroughly review those applications within the allotted time.

The integrity of the rate review system, therefore, can be seen to rely on the good will of the regulated industry. So long as the industry feels well served by the overall regulatory program, the system most probably is not in jeopardy. Adverse circumstances may, however, create divergent interest between the State and hospitals and among hospitals themselves. Under such circumstances, the existing program could be victim of a willful overburdening of its mechanisms.

Recognizing its limited resources, the commission has developed administrative alternatives to a full rate proceeding through the inflation adjustment system and the guaranteed inpatient revenue systems. Hospitals tend to regard regular rate proceedings as unreasonably expensive. There is, therefore, an incentive for them to accept the automatic increases. These formula based rate setting methods require considerably less staff time to apply than would be required to conduct formal review for all cases.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male; 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia, may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Hospital rate-setting: Should Michigan adopt it?

By Rhoda Powsner, MD, JD
Ann Arbor

Hospital reimbursement regulation, or rate-setting, is a regulatory mechanism which seeks to compel more efficient delivery of care through budgetary constraints imposed by a rate-setting commission.

Unlike certificate-of-need (CON) it is a form of regulation which has not been widely adopted. The majority of the eight states with legislatively mandated rate-setting are located on the east coast and are highly industrialized: several have large welfare populations which receive generous benefits.

Prior to regulation these states, as a group, experienced higher average hospital costs than the rest of the country, including Michigan. Following adoption of rate-setting, however, the rate of growth of their hospital expenditures dropped. Never-the-less, average hospital expenditures per capita in these regulated states still exceed those of states without reimbursement regulation.

Growth decreased

From the New York experience it appears that rate-setting with tight budgetary constraints decreases the rate of growth of hospital expenditures at the expense of existing institutions. On the other hand, the New Jersey and Maryland experience with more flexible rate-setting seems to demonstrate that existing institutions can remain solvent while costs continue to rise at a controlled slower rate. The important question not yet resolved, however, is whether rate-setting, itself, is the mechanism responsible for the apparent reduction in the rate of growth of hospital expenditures; or whether other factors such as budgetary constraints imposed by Medicare or Medicaid contribute to the observed decrease.

There is some suggestion that the states which adopted rate-setting were more technologically sophisticated and that reimbursement regulation slowed the rate of technological change, thereby decreasing expenditures. Another suggestion is that regulation has encouraged more efficient hospital management and a shift from more costly inpatient to less costly outpatient care. Such suggestions are hard to assess on the basis of available data. Many of the trends noted in regulated states have been seen in states which have not adopted mandatory rate-setting.

While it is hard to justify rate-setting on the basis of experience it is even more difficult to justify it theoretically as a mechanism for hospital cost containment. The hospital industry is not a single firm, natural monopoly — the situation in which price controls classically may be expected to maximize cost-effectiveness. Rather, the hospital sector is made up of a variety of firms, each with its individual costs and demands and each supplying a multitude of services. The very complexity of these relationships precludes the use of classic utility regulation to correct market failure.

In the past physicians were blamed for misallocation of resources in the health care system: it is now obvious that many factors are responsible. They include cost-based hospital reimbursement to a non-profit industry; lack of consumer involvement in the purchase of health insurance and medical care; the present federal tax structure which exempts from taxation employer contributions to employee health insurance premiums, and does not tax these amounts as wages; the configuration of the health insurance market, with dominance by Blue Cross, especially in highly industrialized states; and control of capital investment through CON.

Rate-setting does not correct any of these causes of market failure. At best, rate-setting may reduce inefficiencies resulting from organizational slack and from delivery of care that is only marginally cost-effective. It is conceivable that rate-setting, if not too restrictive, can be useful as a temporary device to moderate the rate of growth of hospital expenditures until deregulation and restructuring of health care financing reduce misallocations.

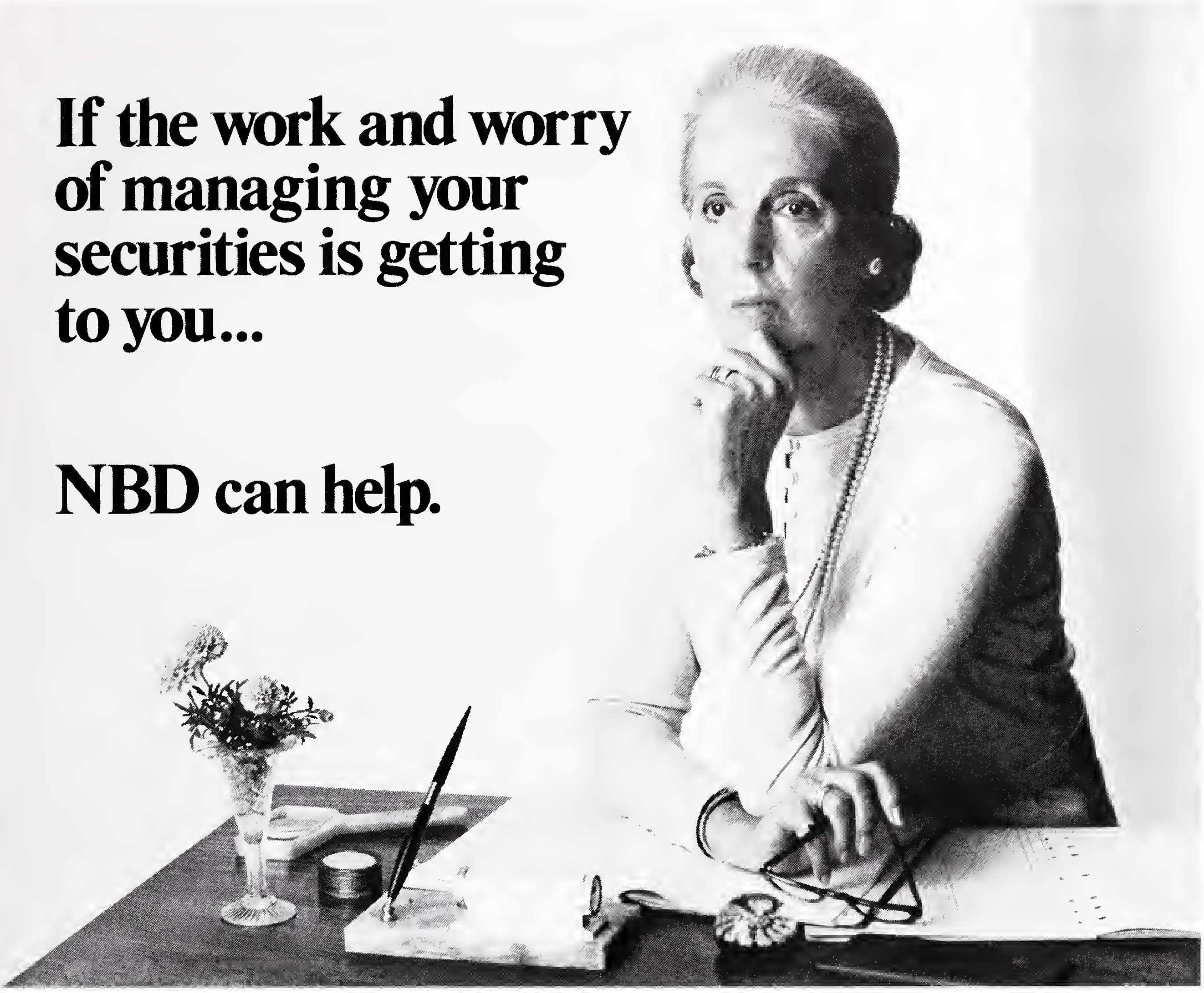
Rate-regulation's success as a regulatory mechanism ultimately depends on whether it reduces the inefficiencies in the hospital sector without compromising the quality of care. While some tentative conclusions have been drawn about the effect of rate-setting on expenditures, no information has been compiled on its impact on care.

Unlikely here

Will rate-setting help Michigan to resolve its current budgetary crisis? Not likely. While the adoption of rate regulation may silence critics, it is improbable that anything short of the actual capping of hospital expenditures will result in even short run savings. On the basis of experiences in other states, even if rate-setting is successful in reducing the rate of growth of hospital expenditures these effects are not likely to be manifested for many years. Moreover, since there is still uncertainty about the long term effectiveness of rate-setting even in New York, which has shown the greatest response to reimbursement regulation, it is imperative that possible benefits be realistically assessed before an elaborate rate-setting mechanism is put into place in Michigan. Contemplation, not precipitous action, is required at this point.

Physicians should use the debate over hospital reimbursement regulation as an opportunity to re-evaluate the effectiveness of current medical practices. We should also be prepared to take an active role in designing and implementing changes which will permit appropriate care at reasonable cost.

Doctor Powsner is a cardiovascular surgeon, a lawyer, and is a member of the Ad Hoc Task Force on Rate Regulation, a subcommittee of the MSMS Committee on State Legislation and Regulations.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Physicians' notification of the audit

The Participating Physician's Registration and Agreement with Blue Shield of Michigan, which every participating physician signs and agrees to, states "I (the physician) hereby register as a participating physician under the service plans of Blue Shield of Michigan, and agree to serve Blue Shield members and accept payment for covered services in accordance with the terms of the subscriber's contract in force at the time of my services."

Since the physician agrees to service Blue Shield members in accordance with the terms of the subscriber's contract in force at the time of his/her service, and since all subscriber contracts authorize BCBSM to examine their records, the physician has agreed to this examination by signing the participation agreement with Blue Shield.

As for providers who participate on a case-by-case basis, the BCBSM Michigan Medical Claim Form, which they must use, states:

"If payment to Physician/Provider:
'I certify the services herein were performed personally by me or under my direct and personal supervision and in my presence, and are submitted in accordance with the provisions of the subscriber's contract.'"

Therefore, because these case-by-case physicians also agree to submit claims to BCBSM in accordance with the provisions of the subscriber contract, they too have agreed to the examination of BCBSM subscriber records by the signing and submitting of the Medical Claim Form.

The BCBSM Physician's Manual advises physicians that BCBSM conducts audits and further explains their purpose. BCBSM also tries to accommodate physicians as much as possible during the auditing process. This may be accomplished by rescheduling audits if the original time is inconvenient for the physician, and by not disturbing the physician's office during the audit. However, accepted auditing practices dictate that providers should not be advised of the exact nature and scope of a particular audit.

BCBSM's need for using auditing procedures is reasonable and understandable. BCBSM's intent is to insure cost efficient health and medical care coverage, not to harass physicians, providers or subscribers.

Sincerely,
Armen Shekerjian, MD
Vice President and Medical Director
Medical Affairs Group
Blue Cross Blue Shield of Michigan

Drug abuse

We appreciate the article you ran in the March, 1982 issue of *Michigan Medicine* on the drug abuse prevention plan developed by the medical community in Macomb County. Unfortunately, a misunderstanding about the timing of the plan may have misled your readers.

We first began meeting with some of the co-sponsoring organizations in October, 1981. The program itself, however, was not due to begin until May 3, 1982. Therefore, some of the other activities you mentioned, including notifying the appropriate doctors and pharmacists, did not happen until April, 1982.

We were still in the process of negotiating the wording on the Schedule II policy when I discussed it with *Michigan Medicine*. Your description of that policy was essentially correct, in concept, but your readers may want to know the final wording, as adopted by our society and the societies representing the Macomb osteopaths, dentists, pharmacists and podiatrists.

It reads:

1. A 24-hour delay will be required in the filling of all Schedule II prescriptions. The only exceptions will be in cases of acute need and unusual hardship. (See below.)

2. During that 24-hour wait, the pharmacist will call back to the prescribing doctor, or similarly licensed designee, to verify the legitimacy of the Schedule II prescription. It is our policy that the confirmation call will only be made to doctors in their offices, where the prescriber has access to the patients' charts.

3. In situations where the Schedule II drug has been prescribed for an acute and immediate need, the "Rule of 16" should be followed: A maximum of 16 doses of the drug may be dispensed immediately. If more than 16 doses are needed, the remainder of the prescription may be dispensed 24 hours later, after the pharmacist verifies the prescription with the prescribing doctor. *The balance of the prescription must be picked up within 72 hours.*

4. There may be a few cases in which it would be an unusual hardship for the patient to have to return 24 hours later for the prescription. In those cases, pharmacists should use their professional judgement in balancing abuse potential against that hardship. The pharmacist may fill the prescription after attempting to verify it with the prescribing doctor.

5. If the prescribing doctor, or the doctor's similarly licensed designee, cannot be reached within 24 hours to check on a Schedule II prescription, the pharmacist may fill the prescription and verify it as soon as the doctor becomes available. A log should be kept of all unverified Schedule II prescriptions over 16 doses.

6. Amphetamines, including methamphetamine, should not be used in appetite control because their abuse potential far outweighs any anorectic benefit. We urge all doctors to discontinue prescribing these drugs for weight control.

We are very proud and excited by this cooperative action on drug abuse here in Macomb County. Thank you for your article. We will let you know what has happened six months from now.

Peter Nowosielski, MD, President
Macomb County Medical Society

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Remembering Mac

By Kenneth H. Johnson, MD
Lansing

Oliver B.
McGillicuddy, MD

This article is adapted from one first appearing in the bulletin of the Ingham County Medical Society.

When I think of Mac, I always see the same image in my mind — a big man, slightly stooped from long hours at the operating table, with beautiful hands and long tapering fingers, a frank, open countenance, dancing eyes, and always that little half smile which sometimes gave way to the gusto of a real belly laugh.

I first met Doctor McGillicuddy in 1932 when I came to E.W. Sparrow Hospital, Lansing, as an intern. Doctor Mac had just arrived in Lansing after five years in the otolaryngology department of University Hospital under Doctor Canfield and Doctor Furstenburg.

Following the summer of 1934, I began practice. Doctor McGillicuddy's office was in the same building and I referred my difficult problems in otolaryngology to him.

These were the days when everyone took turns caring for the medically indigent. So at regular intervals we physicians would assemble at The Annex in Oak Park where the anesthetists would put our young charges to sleep in one room and carry them to the operating table where the surgeons did the tonsillectomies and adenoidectomies.

Doctor Mac was one of those surgeons and I recall being impressed by his gentle touch, the sureness of his technique, the little twist of his finger with a loop of suture material as he tied off a bleeder. Some time later, he taught me his technique, which I considered superior to the Sluder's and other methods I saw there.

One of the great attributes of Oliver's personality was his consideration of other people, especially his patients. He treated them as equals, regardless of their station in life. This was equally true in his personal life.

I learned a great deal about Oliver through our golfing partnership. For instance, Oliver loved to drive the golf cart we rode; so much that if his clubs were placed on the passenger side, he would change them to the driver's side.

Being a competitor, he never gave a thing. One had to win every point; nothing was granted. The rest of our foursome usually consisted of Herb Harris, MD and Ed Robson, MD. Mac and Herb used to razz each other's poor shots, with a long, loud, horse laugh. One day they decided that they would either applaud or say nothing. This lasted through the fifth hole of one game, when, with great relief and alacrity, they decided "this is not fun." They returned to their raucous habits.

At a certain point each of us became involved in organized medicine: Ingham County Medical Society and later MSMS. Oliver served as chairman of the Council, president, and secretary of MSMS.

One of his innovations as chairman of the Council was to limit the time allowed for speaking. He did this by going around the table, giving each member the chance to speak briefly. He moved a second time around for additional remarks. This required each one to have his thoughts in order, cut down on the persiflage, and arrived at a consensus which the majority could easily support.

Another trait of his personality was that he was a man of conviction. He was in no way dogmatic; but if his intellectual pursuit of a matter led to a specific conclusion he did not waiver. At the same time he used discretion in implementing his conclusion.

A case in point occurred while he was secretary. It was at a time when there were very strong feelings on each side of a debate as to which course MSMS should take. Oliver had taken a position from which he refused to retreat. One the other side were certain advocates of the opposition who also refused to abandon their position. As a result of this stalemate Oliver resigned as secretary. In his judgement, he saw no other course to prevent a serious schism in the society itself. Many of us did not agree, because we thought he should have risked such a calamity rather than give in; but he had thought it out carefully and acted accordingly, based on his personal conviction.

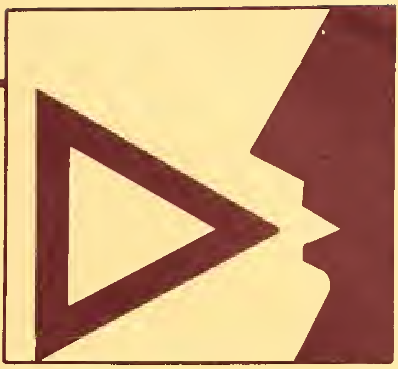
While this is intended as a personal tribute to Oliver, I must include a comment about his wife, Bernie, and his children, Anne and Jane. It was always a delight to be invited to their homes in East Lansing and at Glen Lake. One could not but appreciate the sense of fulfillment, basic integrity and beauty of the lives of the people who dwelt therein. This eulogy to Oliver would be incomplete without proclaiming the tremendous support Bernie accorded Oliver. She believed in him without reservation and made his goals her goals with unstinting devotion.

So, Oliver, we will miss your smile, your strength, your fairness, your talents, your wisdom, your concerns. Perhaps God has a medical community in Heaven, where you again may serve as chairman of the Council, president, and/or secretary.

Godspeed.

Doctor Johnson is past president and former secretary of MSMS.

Meeting the challenge of the 80's



Your image is important to your success as a practitioner

The public perception of physicians may be as harsh as indicated in a study conducted at the University of Utah: "Doctors are too tired, too overworked, too expensive, too wealthy, and too hard to talk to." But there are other surveys that reveal a high degree of public satisfaction with the medical profession. A 1981 Gallup Poll commissioned by the AMA reported that 90 percent of the public is "very" or "fairly" satisfied with medical care.

Surveys designed to check national public attitudes often do not lead to identical or even comparable conclusions. Differences in methodology, selection of participants, implications of the questions, and interpretation of responses lead to disparate results, inferences, and generalizations. There may be some validity to the skeptic's assertion that survey results are affected by who wants the information and who is paying for it!

Among doctors there is limited agreement on the public's perception of medical practitioners. The temptation is to accept and cite poll results which place physicians at or near the top of the "we-think-you're-great" scale — a comfortable, reassuring position, but perhaps illusory.

Surveys indicate that most doctors believe they have good rapport with their patients; some seek to improve relations, while others don't give a damn. If the latter group took the attitudinal pulse of the patients in their waiting (and waiting, and waiting) rooms, they might reconsider their proclaimed disinterest.

Physicians who admittedly care about their image may find a self-conducted survey more helpful than those done by pollsters such as Gallup, Harris, and Roper. Many doctors think they know what is needed to improve relations, but they aren't quite sure. The answer can come from their own patients.

Objective survey results will reveal more than the existence of a problem. They can, and should, point to what specific conditions, acts, or failures to act lead to favorable (or unfavorable) attitudes, images, or relationships.

A busy, conscientious physician might ask, "Why bother? I already have more patients than I can handle and all of my associates are on duty more hours than they like. Isn't the number of patients we have indicative of our good public relations?" Not necessarily.

Although we hear a great deal today about an oversupply of doctors, residents of many cities, towns, and rural areas don't know it. They are going to any doctor within a reasonable distance who will see them — a choice of doctors is non-existent. In Michigan, for example, there is one county with a population of 2,000 that has no physician; another with 7,500 residents has only one physician. There are pockets of need for doctors in many metropolitan areas as well. This paucity of medical practitioners in certain locations may account for patients who keep returning even when dissatisfied.

Ask the patient

In several issues, *Medical Economics* has examined the art of conducting surveys on physician-patient relations. Authors of the articles are usually doctors who conclude that the best way to find out what is wrong, if anything, with the way you practice medicine or run your office is to ask almost anyone except the patient.

Under the title, "For a *Real* Survey of Your Practice Ask Your Employees" in the July 20, 1981 edition, Forrest P. White, MD, wrote that " . . . it seemed a bit risky" to ask patients — so they asked their nine employees for an evaluation. As it turned out, they learned a lot more about worker dis-satisfaction than patient discontent.

Another article in the February 16, 1981 *Medical Economics* asked the title question, "How Do You Rate with Patients?" and proceeded to conclude, without asking any of the patients, "you don't have to take a poll . . . (just) read carefully between the lines in day to day encounters." Most patients, however, unlike the impatient examples cited by the author Ross L. Egger MD, don't pop off, they just simmer quietly. You'll never know what's bothering them if you don't ask!

Hearsay evidence is prescribed as the way to get the facts by Marianne G. Dekker, Associate Editor, in a 1976 *Medical Economics* article. Under the title "As Doctors See It: Why Patient Relations Go Wrong" physicians charged that their colleagues "don't take time to listen to the patient;" "They keep people waiting unconscionably long periods with callous disregard for the patient's time;" "they show too much interest in the monetary end of practice." Mostly the accusing doctors were basing their judgments on charges made by disgruntled *patients* who came to them after unhappy experiences with other physicians.

The reality seems to be: you cannot diagnose the problem if you don't examine or even consult the patient. Through an effective survey of patients, you can locate the source of pain. Then you can follow the usual procedure of diagnosis, treatment, prescription, and followup.

Survey will help —

Surveys need not be expensive nor time-consuming to administer. They do, however, provide valuable information concerning where you stand with your patients on the satisfaction scale. If you aren't prepared to hear some bad news, don't ask — though there are some compelling reasons for you to do so:

- Patients who are pleased with their doctors are more apt to take prescribed medication, get better sooner, and demand less service.
- Patients who are unhappy will appreciate the opportunity to vent their displeasure.
- Patients will be favorably impressed by the doctor's consideration of their opinions.
- Patients will believe the doctor is sincerely trying to improve conditions and procedures for their benefit.
- Results of the survey will direct attention to the need for changes which might otherwise go unnoticed.

You may or may not be able to cure the ailments identified by the survey. But just conducting it is almost certain to improve your patient relations and reduce the number of problem patients.

Why not ask your patients how you're doing? Try the sample survey next page.

General tips for preparing and administering a patient survey questionnaire:

- Confine your questions to information you *really* need.
- Give the respondent an idea of why it is in his or her best interest to answer.
- Ensure that the questionnaire is neatly designed, well-printed, has ample response room, and appears important.
- Test for clarity, ease of response, and overall appeal by having acquaintances complete it.
- Ask each patient to fill out the form and deposit it in a box clearly marked and conveniently located for that purpose.
- Do not require the patient to sign the survey — anonymity brings honest answers.
- Continue the survey for a specific time period (two weeks to a month) and repeat it annually.

This is a sample survey questionnaire. You may choose to use it or something comparable for your purposes.

Patient attitude survey

This survey is your opportunity to comment on our services. We are making an effort to improve our office policies and procedures and need your help. Thank you for your cooperation.

1. What factors influenced you to choose me as your doctor?

____ near home or business
____ referral by another patient
____ referral by another physician
____ referral by local medical society
____ telephone listing
____ other ____________

2. Did you find it easy to get an appointment?

____ YES ____ NO

If no, please explain: ______________

3. When you last called our office, how were you treated?

____ royally
____ courteously
____ coolly
____ poorly

4. When you arrived at our office, how long after your scheduled appointment time did you have to wait to see me?

____ less than 15 minutes
____ 15 to 30 minutes
____ more than 30 minutes

5. What is your general impression of the waiting area?

____ pleasant
____ adequate
____ unpleasant

6. Is there usually enough seating?

____ YES ____ NO

7. Are reading materials suitable and in good condition?

____ YES ____ NO

8. Is the waiting area adequately lighted?

____ YES ____ NO

9. How are you treated by my office staff?

____ pleasantly
____ indifferently
____ coldly

10. How would you rate me on my patience and interest in your problem?

____ outstanding
____ good
____ indifferent
____ don't have time for me

11. How do you feel about interruptions of our time together in the exam room?

____ has never bothered me
____ has happened once too often
____ I'm ready to look for another physician

12. At your last visit was the fee itemized and explained to you?

____ YES ____ NO

13. Do you feel the fee I charged was reasonable considering the services that were performed?

____ YES ____ NO

14. Did you receive adequate assistance in filling out insurance forms?

____ YES ____ NO

Additional Comments: ____________
____
____
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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

Dalmane® Ⓒⅳ
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15-mg/30-mg capsules

Efficacy objectively demonstrated in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.

In numerous sleep laboratory investigations patients fell asleep sooner, slept longer and woke up less during the night[3-12] with

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Fewer middle-of-the-night awakenings[4] with

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More total sleep time on nights 12 to 14 of therapy[4] and continued efficacy for up to 28 nights[5] with

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Rebound insomnia is avoided upon discontinuation [3,4,7] of

Dalmane®

Low incidence of morning "hangover"[14] with

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The efficacy of Dalmane has been studied in over 200 clinical trials with more than 10,000 patients.[3-15] During long-term therapy, which is rarely required, periodic blood, kidney and liver function tests should be performed. Contraindicated in patients who are pregnant or hypersensitive to flurazepam.

Please see summary of product information on following page.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Time to plan for 1982 MSMS Annual Scientific Meeting

Michigan physicians may begin making their plans today for the 1982 MSMS Annual Scientific Meeting. The three-day Category I continuing medical education event is scheduled Nov. 9-10-11 at the Hyatt Regency Dearborn.

Frank Cox, MD, director of the Office of Continuing Medical Education at Henry Ford Hospital, and his Annual Scientific Meeting Task Force are arranging a full schedule of courses which reflect the times.

With the explosion in medical and scientific technology, several new courses are designed to help physicians better understand the new developments and equipment and how to use them to improve their patients' care.

Technological sessions include courses on nuclear cardiology, obstetrics/gynecology, ophthalmology and mechanical ventilation.

Other new courses are planned to help physicians care for the victims of violence, to delve into the special medical and social problems of families of various ethnic origins, individual physicians' ethics, multiple sclerosis, and the medical ramifications of the proposed Michigan mandatory seat belt law.

For the first time, the Michigan Board of Medicine is working to develop a course, joining the Michigan specialty societies and Michigan medical school departments which traditionally develop and present courses.

Doctor Cox and his committee again are working to ensure there is something for every specialty, for generalists and subspecialists. Courses again will be presented in a compact area of the easily accessible Dearborn hotel, with registration and exhibit booths all within shouting distance.

Please watch these spaces, as well as the MSMS *Medigram* newsletter, for more complete course and faculty information, as well as registration forms and housing information. For details, contact Sherry Fent at MSMS headquarters.

MSMS Sports Conference report

Perhaps we're emphasizing wrong sports

By Kim Dean
East Lansing

Principals at the conference were, from left, Roy Bergman, MD, Escanaba, speaker and 1980 US Olympic Team Physician; Gerald A. O'Connor, MD, Ann Arbor, program chairman, and MSMS Sports Medicine Committee member, and Bernard Cahill, MD, Peoria, director, Great Plains Sports Medicine Clinic.

The key to treatment in athletic injuries is not abstention from all activity. Nor is it a shortened workout. Recovery is dependent upon rest and progressive resistant exercises.

This is the conviction of Bernard Cahill, MD, Director of the Great Plains Sports Medicine Clinic in Peoria, Illinois, who was major speaker at the 1982 MSMS Conference on Sports Medicine. In his three lectures on "Evaluation and treatment of chondromalacia of the patella," "Chronic shoulder pain in the athlete" and "Twelve year followup on the effect of preseason conditioning on decreasing knee injuries in high school football," he stressed the idea of modifying both preseason and post-injury training methods.

Preseason conditioning creates an environment that causes athletes and coaches to alter their reactions and motivations, he says.

"The athlete," says Doctor Cahill, "becomes aware of the potential benefits of preseason conditioning and tends to create his own conditioning program. He is motivated by a desire to 'make the team' and by anxiety over injury."

Fringe benefits of a structured preseason conditioning program are a decrease in other injuries, an increase of injury awareness in the community and a carry over of concern to other sports.

If an injury or a chronic pain syndrome does occur, rest, meaning a period of time that is symptom free, where no pain or discomfort is experienced by the athlete, is essential. "It does no good, says Cahill, "to remove an athlete from his sport if pain continues with the activities of daily living."

The 16th annual MSMS Conference on Sports Medicine at the Plymouth Hilton Hotel was attended by over 125 physicians, coaches, trainers and students. The conference presented the techniques necessary for early evaluation and recognition of athletic injuries, with an emphasis on giving early treatment.

"The principle interest and emphasis of this conference," said Gerald A. O'Connor, MD, program chairman, "is centered on the recognition and early treatment (on site) of athletic injuries, as opposed to esoteric surgical intervention and later medical efforts."

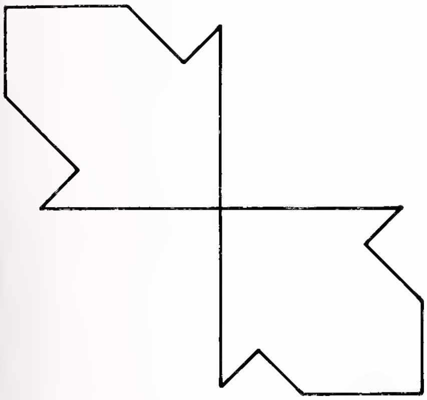
In his discussion of athletic injuries in the adolescent, Robert Hensinger, MD, professor of surgery, Section of Orthopaedics, the University of Michigan, emphasized his concern over the "weight lifter's" syndrome. This syndrome frequently comes from the athlete's early lifting, concentration on upper body and poor supervision. The resulting impingement syndrome (also noted by Doctor Cahill) is symtomized by mild pain after the activity. This progresses to pain while the activity is being performed and finally leads to the point where it interferes with the performance of the athlete.

Douglas McKeag, MD, Coordinator of Sports Medicine in the College of Human Medicine at Michigan State University and Associate Professor of Family Practice, stated that the pressure to win is an adult creation. In fact, while training has a definite effect in post-pubertal young adults, athletic training in pre-pubertal youngsters no appreciable effect, he said.

Based upon a Harvard study on life span, Doctor McKeag suggested that in terms of health education of children, perhaps our society is emphasizing inappropriate sports . . . those which do not allow participation in later years.

Ms. Dean was a communications intern with MSMS at the time of this writing.

MEETINGS



MSMS, MSMS/A, AMA, and medical assistants

June 30 — MSMS/INTRAV Rhine River Adventure (14 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

July 11-14 — The Council Midsummer Session, Grand Traverse Hilton, contact: Warren F. Tryloff, MSMS headquarters, 517/337-1351.

July 17-18 — Medical Assistants Summer Seminar, Spring Lake Holiday Inn, Spring Lake, contact: Caroline Rich, MSMS headquarters.

July 18 — MSMS/INTRAV Alpine Adventure (15 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

July 30-Aug. 1 — Upper Peninsula Medical Society and Auxiliary Meeting, Marquette, contact Caroline Rich, MSMS headquarters, 517/337-1351.

Sept. 20 — MSMS/A State Board Meeting, MSMS headquarters, contact Caroline Rich, 517/337-1351.

Sept. 22-25 — AMA Fifth National Conference on the Impaired Physician, Portland Marriot, Portland, Oregon, contact: AMA, 312/751-5109, 535 N. Dearborn, Chicago, IL 60610.

Oct. 1-14 — MSMS/INTRAV Nile River Adventure, contact Marce Ireland, MSMS headquarters, 517/337-1351.

Oct. 10-12 — MSMS/A National Leadership Confluence, Drake Hotel, Chicago, contact Caroline Rich, MSMS headquarters, 517/337-1351.

Oct. 28 — MSMS Leadership/Public Affairs Conference, Long's Convention Center, Lansing, contact: Bill Madigan or Kevin Kelly at MSMS headquarters.

Nov. 8 — MSMS/A State Board Meeting, MSMS headquarters, contact: Caroline Rich, 517/337-1351.

Nov. 9-10-11 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

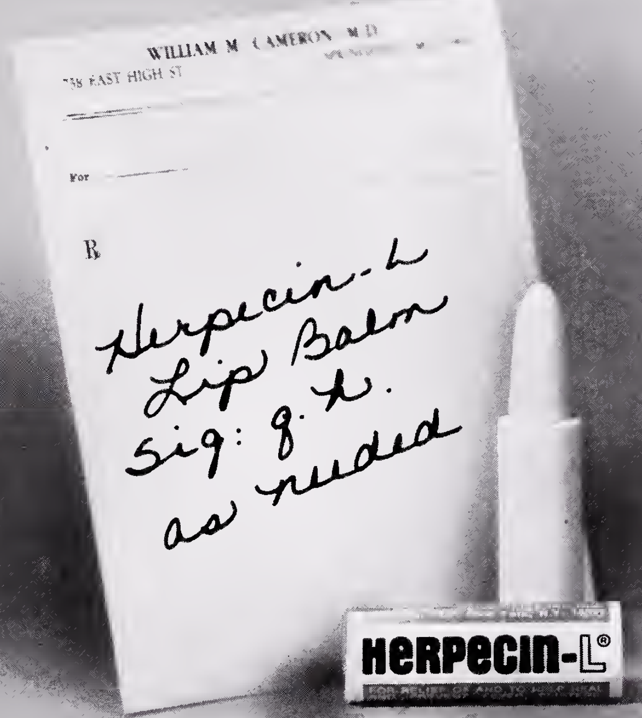
July 28 — Council Meeting, Michigan Chapter, American College of Surgeons, Park Place Hotel, Traverse City, contact: Vi Heins, MSMS headquarters, 517/337-1351.

Aug. 20-22 — National Convention, Physicians of India Association, Detroit, contact: Doctor Kothari, 313/644-1269. Scientific & Academic Meeting to be held Aug. 21, contact: Doctor Ravindranath, 313/643-7725.

Other meetings

Sept. 9-10 — National Meetings on Physician Maldistribution, sponsored by the U-M School of Public Health, contact Department of Conferences and Institutes, U-M Extension Service, 412 Maynard Street, Ann Arbor 48109.

Dx: recurrent herpes labialis



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VIEWS

Required MD coverage last resort to solving hospitals' liability problems

By John R. Ylvisaker, MD
Pontiac

There is an ominous unrest in the hospital industry in Michigan over the "threat to corporate assets" caused by increasingly high awards against hospitals for claims arising from in-hospital medical care. Legal advice is creating a trend for hospitals to require malpractice liability insurance of minimum limits (or a guarantee of financial ability to pay — "assurance") as a condition of medical staff membership. This issue is controversial and is creating an undesirable adversary relationship between hospitals and their medical staffs/medical staff members.

Is there a problem?

Hospitals: The March 1982 Bulletin of the American College of Surgeons quoted 1975-1978 study by the National Association of Insurance Companies of closed claims reported by 128 insurers. This study noted that "78 percent of incidents resulting in paid claims occurred in hospitals. Physician-defendants accounted for 71 percent of the total amount of indemnity paid by insurers." In other words, over 70 percent of all malpractice settled cases were the result of physician related activity occurring on hospital premises.

Increasingly, the hospital is singled out as the major target in lawsuits for incidents occurring on hospital premises whether or not an employee relationship exists. Physician staff members are jointly sued, but the hospital represents the "deep pocket" because it possesses the greatest assets, the largest insurance coverage, and because the physician staff member may be uninsured, inadequately insured, or have limited financial ability to defend or pay claims.

The cost of medical liability coverage for hospitals has been rising sharply as claims have increased in frequency and awards have broken records. A recent award of $14 million is an example. The cost of such coverage for larger hospitals may exceed two percent of the total budget and involve amounts exceeding several million dollars in annual premiums.

The **legal basis** for the concern of hospitals is well-established and supported by case law: Four legal principles are central to the issue:

1. Hospitals have **"corporate responsibility"** for any and all activities occurring in the hospital.
2. The administrators, owners, and trustees of hospitals have **"fiduciary responsibility"** to maintain corporate responsibility and to protect the assets of their hospital.
3. Pleadings are permitted, and awards granted, on the basis of **"joint and several liability"** making the "deep pocket" of hospitals responsible for judgments not covered by uninsured (or poorly insured) physician staff members.
4. Hospitals have been accorded the legal right to require each physician who provides medical care on the hospital premises to carry liability insurance of "appropriate limits."

It is clear that for hospitals the problem **is** real. The pressing current question is: "What to do about members of medical staffs who are 'going bare' or have inadequate insurance coverage"?

Physicians: It surprises many that physicians share this problem.

But the problem is two-fold:

Does the hospital's insurance protect the physician who performs teaching, emergency, and critical committee functions (such as credentialling, and disciplining)?

Does each colleague, who shares medical care responsibility in team care of hospitalized patients, have insurance or sufficient resources to satisfy legal defense and court award costs if a patient sues?

At present, most medical staff physicians are not informed by either the hospital or colleagues of what protection exists, if any. When suits are filed against physicians, "joint and several liability" make the physician who is insured the main target for the claim. Hospital insurers frequently look to the physician's coverage as "primary" and avoid initial responsibility (especially for required medical staff functions). Also, the uninsured colleague makes his insured co-worker vulnerable both for defense and for collectibility. This is not only unfair, since the uninsured party hasn't had to pay insurance premiums, but potentially explosive because it may, and frequently does, cause physicians to sue fellow physicians or cause cross-litigation between physicians and hospitals.

So, for physician medical staff members the problem is also serious and substantial, but probably not as widely recognized.

Mandatory insurance/ financial assurance?

The pat and simple recommended solution seems to be: Require every physician on the medical staff to carry malpractice insurance with mandatory limits as a condition of medical staff membership — or, as an alternative, require a "certificate of financial assurance," i.e. a document which guarantees an "ability to pay."

The latter alternative has little or no merit unless it were accompanied by a requirement to provide a bona fide bond. The criteria for, and the verification of validity of, any certificate of financial assurance alone makes this approach unworkable.

Mandatory insurance has merit and has precedent in other industries, but fails to take into account the

Continued on page 331

Doctory Ylvisaker is past president of MSMS, and MSMS representative to the Michigan Health Care Coalition.

It all adds up,

in today's major hypertension studies

VA Study[1]

- 450 patients studied
- Mild to moderate hypertensives
- Comparison of propranolol and reserpine for Step-2 antihypertensive therapy
- **Conclusion:** when added to a thiazide diuretic, reserpine was effective in a larger percentage of patients (88%) than was propranolol (81%)!

HDFP Study[2]

- More than 10,000 patients studied
- Conducted at 14 centers over 5 years
- Proved that compliance with Step Care lowers death rate from all cardiovascular causes
- **Conclusion:** reserpine-thiazide regimens were *preferred* for Step-2 therapy, and were deemed effective, without significant adverse effects!

MRFIT Study[3]

- 6-year, 12,000-patient study, to be completed in 1982
- Assesses factors that may increase risk of cardiovascular disease
- Preferred Step-2 regimen: reserpine-thiazide
- **Full year's data:** reserpine is causing less depression than methyldopa, diuretics, or placebo!

That's why the combination in

Salutensin®

(hydroflumethiazide 50 mg/
reserpine 0.125 mg)

Is the preferred Step-2 regimen

Please see references and brief summary of prescribing information on adjacent page.

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Salutensin®
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Salutensin-Demi™
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Brief Summary of Prescribing Information (12) 10/27/78
For complete information consult Official Package Circular.

WARNING
This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS
Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS
Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.
Use in Pregnancy—Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS
Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ADVERSE REACTIONS
Hydroflumethiazide—Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.
Reserpine—Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE
The usual adult dose of Salutensin is one tablet once or twice daily. If a smaller amount of thiazide diuretic is desired, Salutensin-Demi, one tablet once or twice daily can be given.

SUPPLIED
Bottles of 10 and 1000 scored tablets.

REFERENCES
1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. Moser M, Kaplan NM, Sullivan JM, Paul O, in discussion: Perspectives on MRFIT: Can the interim data be applied to your practice...? An Interim Report on the Ongoing Multiple Risk Factor Intervention Trial: MRFIT. *New Perspectives on Hypertension* 2(1):10-19, February 1981.

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Auxiliary alive and well, looking forward to 1982-83

By Barbara Grennan
Muskegon

This past year, which I have spent as MSMS/A President, has been very challenging and rewarding. The theme for the year has been "Get In Tune With MSMS/A," a musical incentive which hopefully would emphasize the need for unity and greater involvement between the state, national and county auxiliaries.

One of my personal goals as president was to visit each of the organized counties in the state to establish this rapport and to make the state auxiliary a more visible force in their activities. My objective came close to realization but fell short by two of reaching the goal. I have been in touch with every county group by telephone and letter two or more times this year and that is a big plus.

I learned firsthand of their community activities and their fund raising efforts on behalf of AMA-ERF, scholarship and loan programs and local charities. A tally of these efforts shows a figure in excess of $80,000.00 was earned and donated this year alone.

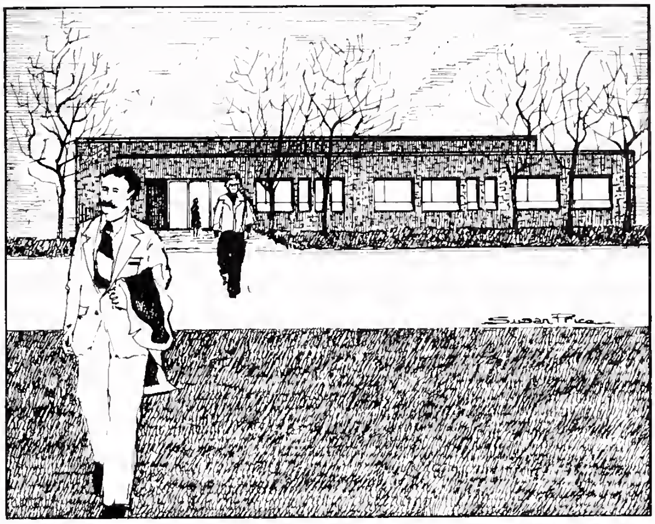
In April, at the House of Delegates, Dorothy Csonka and I were privileged to present checks to the deans of our three medical schools totalling $36,726.61. This represents contributions during the calendar year 1981 and is only Michigan's share of the $1,491,000 raised throughout the country for AMA-ERF by medical auxiliaries.

There is a current country music song entitled "On The Road Again" which has been a most appropriate theme song for my travels this year. As I have traveled I have been able to pass on the successful ideas and projects of one county to others. This combination of personal visits and idea sharing has been very beneficial. Showing our MSMS/A slides has caused renewed interest in World Medical Relief and has sparked auxilians to re-activate or start the collection of materials useful to this agency. The need is great; and WMR President Irene Auberlin, who received this year's MSMS Presidential Citation, is always happy to receive contributions.

"On the road" in 81-82, I have visited 24 of 26 counties, attended three AMA Auxiliary meetings, three out-of-state conventions, the Michigan Association of Hospital Auxiliaries' Convention, State Medical Assistants' Convention, MSMS House of Delegates and MSMS Affairs/Leadership Conference, the AMA Leadership Conference and countless committee meetings. I have logged 15,000 miles on my little, blue Chevette.

The pleasure was all mine. Auxiliary is alive and well and looking forward to 1982-83.

Mrs. Grennan was 1981-82 MSMS/A president.



totally unique aspects of the health care industry and the nature of the hospital/medical staff relationship.

In the construction industry, a "certificate of insurance" or proof of liability insurance is an absolute requirement for contractors, subcontractors, or anyone who sets foot on a construction site. But costs are relatively low, suits are infrequent, and claims are based on observable, well-defined, tangible facts — not so at all in the health care field where subjective, frequently non-meritorious litigation with emotional jury reaction characterizes the climate and escalates costs and insurance premiums.

Cost of coverage makes this approach inequitable because it shifts a responsibility to the physician and medical staff which is basically **a mutual responsibility of both hospital and medical staff.** For the hospital, the premium cost for major protection may seem huge BUT

1) it represents only a small percent of the budget (in the range of one to two percent, and

2) the hospital is reimbursed on a cost basis! For the physician, premium costs are five to ten percent of gross income on average but may represent 50 percent to over 100 percent of gross income in early or late stage of a practice career. And the physician is **not** cost-reimbursed but is dependent totally on unpredictable gross income not related to cost.

The feared consequence of an arbitrary requirement for mandatory insurance coverage is that physicians will be credentialled for staff membership on economic grounds rather than by professional qualification. The young, well-trained physician and the senior, mature physician may be forced financially to abandon private practice or to change location. Hospitals thus risk not only an adversary relationship with their medical staffs but also threaten their lifeline of physician replacement and their anchor of seasoned medical statesmen.

What is the answer?

Basic to the entire problem and its solution must be three considerations:

1. The problem is a shared or joint problem. It is a mutual responsibility of the hospital and the medical staff, each of which is irrevocably dependent on the other for survival. Neither can off-load this problem on the other by ignoring the impact on the other or on the community.

2. The problem is institution - specific. It cannot be addressed properly unless it is clearly defined as it may exist in the local setting.

3. The solution must be **jointly** determined by the hospital and the medical staff on the basis of established case law and especially on the basis of local conditions.

Each institution must attack the problem first in open discussions by well-informed, objective representatives of the hospital and the medical staff. The issue must be fully exposed and explained to the entire medical staff. The experience of the hospital and its medical staff must be studied to determine the number of lawsuits filed within a trailing decade, the number of suits settled or awarded, the estimated total cost of defense, the aggregate dollars paid in premiums and the aggregate of dollar awards — all of this only for claims arising from hospital-based incidents. If patterns of vulnerable activities or physicians are discovered, the reasons should be searched out.

The staff and the hospital next **must** provide **full disclosure** of the status of coverage and the extent of limits of coverage. An intelligent solution is utterly impossible without knowledge of the nature of hospital coverage, the numbers of uninsured physicians, as well as of both hospital and physician policy limits. Disclosure must be a continued practice on an annual basis.

Armed with this information, alternative solutions can be explored. These may include establishing a **pooled risk fund** supported by contributions from the hospital and from medical staff dues — particularly appropos if only a few physicians are uninsured. The concept of back-up **reinsurance** may be the answer to provide guaranteed coverage for large awards and to allow the medical staff to insure only with low-limit coverage on a less costly basis. A third alternative is **self-insurance** of the hospital and medical staff for hospital-based activity and claims. Other solutions may become evident by sound analysis. As a last resort, mandatory requirements for coverage may become the acceptable solution after full exploration of the issue by joint effort.

In summary, the problem of liability coverage for incidents occurring on the hospital premises is a mutual problem of the hospital and its medical staff. The problem is institution-specific and therefore, requires aggressive joint efforts of a well-informed hospital and medical staff for determination of an equitable solution. Full disclosure of the insurance status of both hospital and medical staff members is essential for defining and solving the problem. Mandatory insurance with fixed limits as a condition of medical staff membership should be adopted only as a last resort mutually agreed upon by the hospital and its medical staff.

Glucose screening during pregnancy helps reduce fetal mortality and morbidity

**By Elizabeth Jensen, BSN, MEd
and Molly Graber, RD, MS, Lansing**

A disproportionately high rate of infant morbidity and mortality has long been associated with maternal diabetes. The perinatal mortality rate in Michigan reported among non-diabetic women in 1975 and 1976 was 16.8/1000 live births, while it was 63.2/1000 live births for reported diabetic women. Gestational diabetes, glucose intolerance limited to the period of pregnancy, occurs in one to three percent (and in greater numbers in select populations) of pregnancies. Applying these percentages to Michigan birth statistics, glucose intolerance during pregnancy may be estimated to occur in 1,441 to 4,323 births (based on an estimated 144,129 live births during 1980). Application of current recommendations for the screening and diagnosis of glucose intolerance during pregnancy with subsequent surveillance and control will effect infant morbidity and mortality rates among gestational diabetic women that are the same as those with uncomplicated pregnancies.

This article and accompanying protocol offers recommendations for screening, diagnosis and followup for gestational diabetes. Input has been gleaned from representatives of all physician groups for the purpose of establishing a protocol which is both medically sound and realistic for general office practice.

Traditional methods for the detection of gestational diabetes have been based upon history or overt symptoms suggestive of diabetes and/or the presence of glycosuria. It is estimated reliance on these criteria causes approximately 50 percent of gestational diabetes to go undiagnosed until after birth of an affected child. Research has shown the validity of screening for gestational diabetes in all women not previously diagnosed as having glucose intolerance at 28 weeks (between 24 and 30 weeks) of gestation. At this time, insulin resistance associated with pregnancy is reaching a maximum effect and glucose intolerance is most likely to become evident.

Several methods of screening have been demonstrated to be satisfactory, and are described in the accompanying protocol. However, the most reliable is the 100 gm glucose load given fasting, with a subsequent two hour plasma glucose determination. A positive test, under the conditions of pregnancy, is considered to be greater than 140 mg/dl. A positive screening test necessitates follow-up as soon as possible with a three hour oral glucose tolerance test.

Results diagnostic of glucose intolerance during pregnancy are based upon the criteria established by O'Sullivan. They are defined in the accompanying protocol. A positive screening test followed by a negative oral glucose tolerance test should be followed by a repeat oral glucose tolerance test at 32 weeks of gestation.

Fetal glucose levels are directly related to maternal glucose levels, thus early detection and control of glucose intolerance during pregnancy is important to fetal wellbeing. Fetal hyperinsulinemia can result in macrosomia and may inhibit pulmonary maturation, increasing the likelihood of respiratory distress syndrome or fetal wastage.

The management of glucose intolerance during pregnancy requires care and surveillance at two week intervals until 30 weeks gestation, and weekly thereafter. It is directed at the maintenance of blood glucose levels within normal limits concommittant with fetal wellbeing. Fasting plasma glucose levels should be maintained consistently below 105 mg/dl (below 90 mg/dl whole blood). All these women should monitor urine for glucose and ketones. Glycosuria indicates that diurnal blood glucose patterns should be assessed, whereas ketonuria, particularly fasting, may indicate starvation.

Diet management stresses reducing the intake of simple carbohydrates, distributing complex carbohydrates throughout the day and establishing regular eating patterns. Calories are planned to assure normal prenatal weight gain (usually at least 2,000 kilocalories). Generally, dietary control and modifications will maintain euglycemia.

Approximately 15 percent of women with gestational diabetes will not achieve blood glucose control through dietary modifications and for these, insulin therapy must be instituted. Oral hypoglycemic agents are not appropriate for diabetes control during pregnancy. Women requiring insulin for glucose control should receive the same prenatal, intrapartal and postpartal care as women with overt diabetes. Delivery of the controlled gestational diabetic woman should occur naturally and at term.

Infants of women with diabetes (overt and gestational) are at increased risk for hypoglycemia during the newborn period. Monitoring for the first 24 hours is recommended in the accompanying protocol.

Postpartum Care

Postpartum followup of the gestational diabetic must include a repeat oral glucose tolerance test to assure that glucose control has returned to normal. Usually this is done after the eighth postpartum week when the hormonal influences of pregnancy are certainly terminated. Individual practice variations and patient compliance may necessitate this testing at an earlier time. Women with test results indicating continued glucose intolerance should be referred for care of overt diabetes. Women with test results within normal limits should be advised that approximately 60% of gestational diabetic women will become overt diabetics within fifteen years. The diagnosis of gestational diabetes provides a marker for surveillance. The patient should be advised of the benefit of attaining and maintaining normal weight-for-height by proper nutrition in order to postpone the development of overt diabetes.

Ms. Jensen and Ms. Graber are with the Michigan Department of Public Health Health Promotion and Disease Prevention Administration.

MATERNAL HEALTH DESK REFERENCE CARD NO. 11-A

**(Sponsored and Prepared by the Committee on Maternal and Perinatal Health,
Michigan State Medical Society)**

GLUCOSE INTOLERANCE DURING PREGNANCY
(Gestational Diabetes)

RECOMMENDATION:

All pregnant women shall be evaluated for glucose intolerance during pregnancy.

Where there is a history or symptoms suggestive of glucose intolerance, the women shall have a screening test at the first prenatal visit or when the symptoms are present.

All non-diagnosed women shall have a screening test at 28 weeks (24 to 30 weeks) of gestation.

Women determined by the oral glucose tolerance test to have glucose intolerance during pregnancy shall receive surveillance and intervention as appropriate.

RATIONALE:

A disproportionately high rate of infant morbidity and mortality is associated with uncontrolled maternal diabetes.[1,2] Glucose intolerance limited to the period of pregnancy (gestational diabetes) occurs in 1% to 3% of pregnancies.[3] It is estimated to go undetected in approximately 50% of the cases.[4]

Appropriate screening at 28 weeks (24 to 30 weeks) gestation, when the hormonal effects of pregnancy are maximal, permits identification of the population at greatest risk for glucose intolerance during pregnancy. The cost of screening is nominal. Confirming diagnostic testing following a positive screening test allows for surveillance and intervention to normalize blood glucose levels. Infant macrosomia, morbidity and mortality can be reduced to that consistent with the unaffected population.

1. EVALUATION, SCREENING AND DIAGNOSIS

Steps	Clarifying Information
1. At the first prenatal visit review history for indication of glucose intolerance. Assess for symptoms of glucose intolerance at each prenatal visit.	1. Personal history and symptoms suggestive of glucose intolerance include: a. Previous gestational diabetes b. Previous large infant (≥ 4500 Gm) c. Diabetes in a first degree relative (father, mother, sister, brother) d. Repeated pregnancy losses e. High parity (5+) f. Hydramnios g. Maternal age 25 and older h. Maternal obesity i. Recurrent infection j. Fasting glycosuria k. Complaints of abnormal thirst or urination
2. Women with a history or symptoms of glucose intolerance during pregnancy shall be screened as soon as possible by plasma glucose testing following a glucose load.	2. Any one of the following screening tests may be selected: a. Fifty (50) Gm glucose load given at random with one-hour post load plasma determination. A positive test is considered to be ≥ 150 mg/dl. b. Seventy-five (75) Gm glucose load given at random with a two-hour capillary fingerstick determination. A positive test is considered to be 120 mg/dl or above. NOTE: Refer to manufacturer's recommendation for technique. Deviation will result in errors. c. One-hundred (100) Gm glucose load given fasting with two-hour plasma glucose determination. A positive test is considered to be ≥ 140 mg/dl.

This Desk Reference Card describes methods and techniques of clinical practice that are currently acceptable and used by recognized authorities. However, it does not represent official policy or recommendations of the Michigan State Medical Society and its publication should not be construed as excluding other acceptable methods of handling similar problems.

3. Women who have an abnormal plasma glucose screening test shall receive, as soon as possible, a three (3) hour oral glucose tolerance test (Oral GTT) using a 100 Gm glucose load. The patient shall be prepared for the test.	3. Preparation includes a carbohydrate loading diet, no smoking and fasting. Follow individual laboratory guidelines. Test results are considered positive for glucose intolerance during pregnancy when plasma glucose determinations meet or exceed two or more of the following: Fasting 105 mg/dl blood plasma 1 hour 190 mg/dl blood plasma 2 hours 165 mg/dl blood plasma 3 hours 145 mg/dl blood plasma
4. Women determined to have a positive Oral GTT shall receive surveillance and intervention.	4. See below — II. TREATMENT GUIDELINES.
5. Women not already identified to have glucose intolerance shall be screened at 28 weeks (24 to 30 weeks) gestation.	5. See above — steps 2, 3 and 4.
6. Women who have a positive screening test at 28 (24-30) weeks gestation followed by negative Oral GTT shall have a repeat Oral GTT at 32 weeks.	6. See above — steps 3 and 4.

II. TREATMENT GUIDELINES

1. Women determined to have glucose intolerance during pregnancy shall receive surveillance and evaluation at two week intervals up to 30 weeks gestation and weekly thereafter. Evaluation shall include:

a. Nutritional assessment and counseling.	a. Dietary management is the primary treatment of glucose intolerance during pregnancy. Principles include: 1. eliminate excessive simple carbohydrates 2. encourage four evenly spaced meals 3. distribute complex carbohydrates 4. provide kilocalories to support normal prenatal weight gain (usually at least 2000 kilocalories per day)
b. Monitoring of maternal weight gain and fetal wellbeing.	b. Weight gain should be sequential after the first trimester averaging ¾ pound per week with a total weight gain of 22-27 pounds. Excessive deviations from usual weight gain should be avoided.
c. Prevention of ketonuria	c. Teach patient to monitor urinary glucose and ketones. Check urine for ketones at each visit. The presence of ketones with elevated urine glucose is cause for hospitalization.
d. Maintaining euglycemia.	d. Determine fasting blood glucose at each prenatal visit. Maintain consistently below 105 mg/dl blood plasma (below 90 mg/dl whole blood).

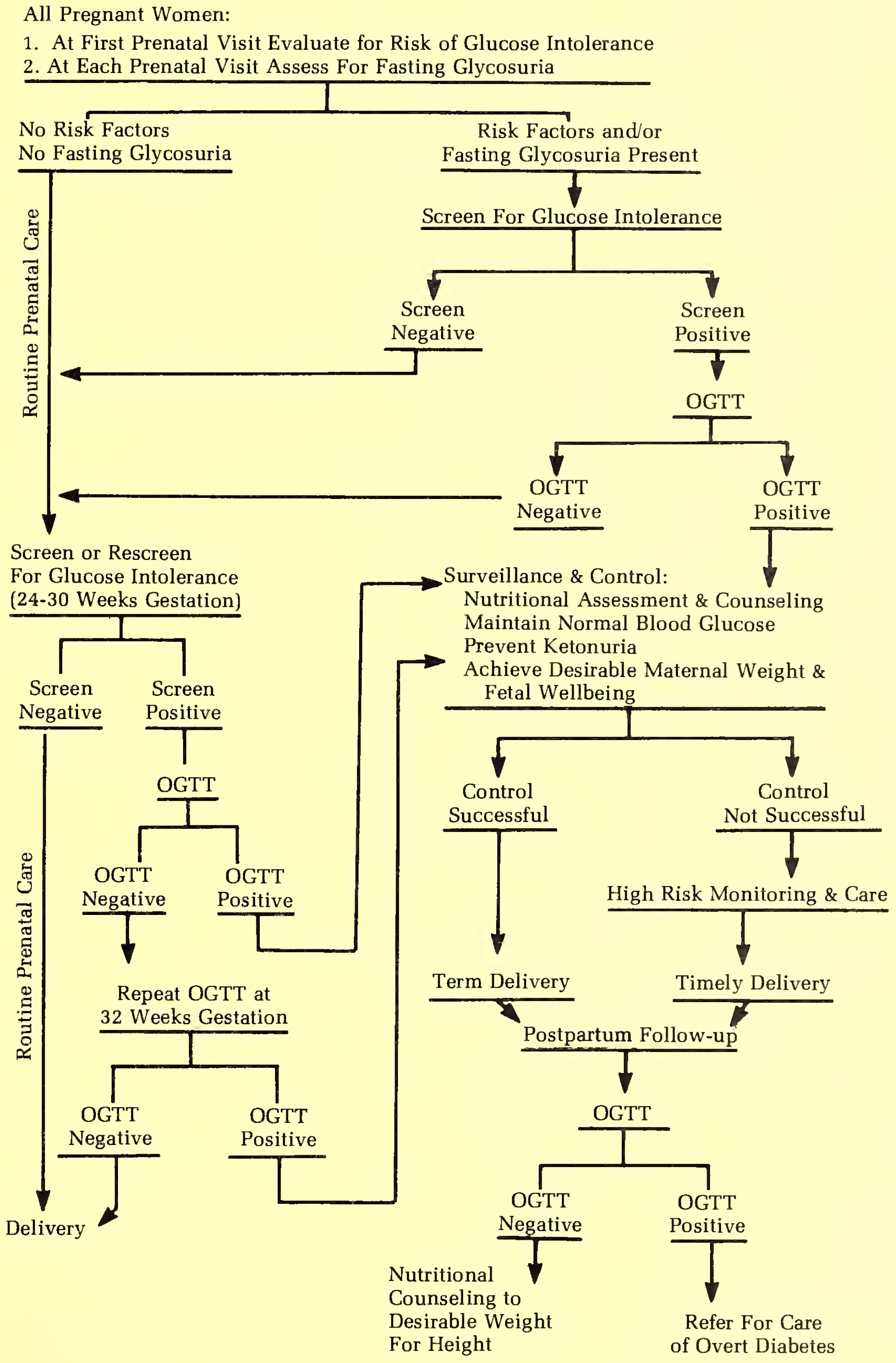
III. DELIVERY AND NEWBORN CARE

1. Delivery of the women with controlled glucose intolerance during pregnancy should occur naturally and at term.
2. Infants born to women with diabetes (overt and gestational) are at increased risk for hypoglycemia during the newborn period. Monitoring for the first 24 hours is recommended and should include:
    - a. Dextrostix every 20 minutes for first 2 hours, at 3 hours, at 4 hours and then every 4 hours for 24 hours.
    - b. If results are below 30 mg/dl, feed with 10% glucose water.
    - c. If ineffective, begin 10% glucose IV.
    - d. Observe for signs of respiratory distress.
    - e. If asymptomatic at 4 hours, transfer from observation to the regular nursery.
    - f. If unable to regulate glucose, contact Regional Neonatal Intensive Care Unit.

IV. POSTPARTUM FOLLOW-UP

1. Women determined to have a glucose intolerance during pregnancy should be scheduled for a repeat Oral GTT during the postpartum period to assure that normal levels of glucose return. This ideally should be done no sooner than eight weeks postpartum.
2. If the Oral GTT is positive, initiate (or refer for) treatment of overt diabetes.
3. If the Oral GTT is negative, advise patient of the probability of later developing diabetes and of the benefit of maintaining desirable weight for height. (Approximately 60% of gestational diabetics will become overt diabetics within 15 years).[6]

FLOW CHART FOR DETERMINATION OF GLUCOSE INTOLERANCE DURING PREGNANCY
(Gestational Diabetes)


All Pregnant Women:
1. At First Prenatal Visit Evaluate for Risk of Glucose Intolerance
2. At Each Prenatal Visit Assess For Fasting Glycosuria
No Risk Factors
No Fasting Glycosuria
Risk Factors and/or
Fasting Glycosuria Present
Screen For Glucose Intolerance
Routine Prenatal Care
Screen Negative
Screen Positive
OGTT
OGTT Negative
OGTT Positive
Screen or Rescreen
For Glucose Intolerance
(24-30 Weeks Gestation)
Surveillance & Control:
Nutritional Assessment & Counseling
Maintain Normal Blood Glucose
Prevent Ketonuria
Achieve Desirable Maternal Weight &
Fetal Wellbeing
Screen Negative
Screen Positive
OGTT
Control Successful
Control Not Successful
Routine Prenatal Care
OGTT Negative
OGTT Positive
High Risk Monitoring & Care
Repeat OGTT at
32 Weeks Gestation
Term Delivery
Timely Delivery
Postpartum Follow-up
OGTT Negative
OGTT Positive
OGTT
Delivery
OGTT Negative
OGTT Positive
Nutritional
Counseling to
Desirable Weight
For Height
Refer For Care
of Overt Diabetes

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This Reference Card was written for the Maternal and Perinatal Health Committee by Molly A. Graber, R.D., M.S. and Elizabeth Jensen, R.N., M.Ed.

May 1982

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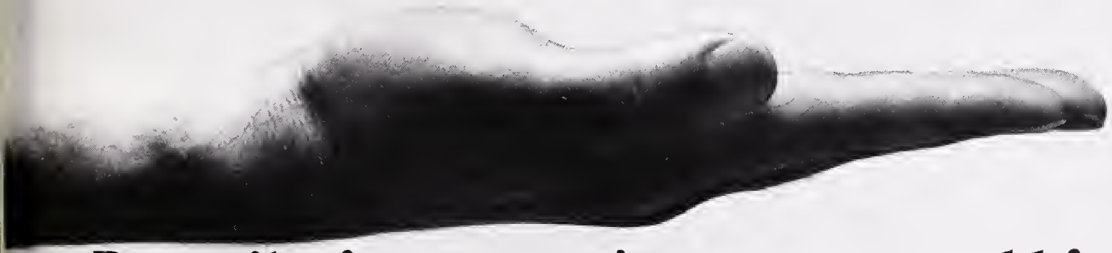

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LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved Contraindicated during acute recovery phase following myocardial infarction

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses Myocardial infarction and stroke reported with use of this class of drugs) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving)

> ***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide)

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients Periodic liver function tests and blood counts are recommended during prolonged treatment Amitriptyline component may block action of guanethidine or similar antihypertensives Concomitant use with other psychotropic drugs has not been evaluated sedative effects may be additive Discontinue several days before surgery Limit concomitant administration of ECT to essential treatment See Warnings for precautions about pregnancy Limbitrol should not be taken during the nursing period Not recommended in children under 12 In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects

Adverse Reactions: Most frequently reported are those associated with either component alone drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs

Cardiovascular Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke
Psychiatric Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido
Neurologic Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns
Anticholinergic Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia
Gastrointestinal Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue
Endocrine Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels
Other Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdosage: Immediately hospitalize patient suspected of having taken an overdose Treatment is symptomatic and supportive I V administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning See complete product information for manifestation and treatment

Dosage: Individualize according to symptom severity and patient response Reduce to smallest effective dosage when satisfactory response is obtained Larger portion of daily dose may be taken at bedtime Single *h s* dose may suffice for some patients Lower dosages are recommended for the elderly Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required Limbitrol 5-12 5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12 5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50

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CATEGORY I COURSES

Michigan Medicine **each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: June 14-18, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine, and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 18, 1982, Child Abuse and Neglect: The Hospital Team Approach. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $95. **Contact:** Office of Continuing Medical Education, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor, 48109 (313) 764-2287. **Approved for:** 7.75 hours of Category I Credit.

Date: June 18-20, 33rd Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Wayne State University Department of Surgery. **Contact:** B. E. Henig, MD, Keyport Clinic, P.O. Box 605, Grayling 49738 (517) 348-6611. **Approved for:** 12 hours of Category I Credit.

Date: June 20-25, 18th Annual Northern Michigan Summer Conference. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** Dept. of Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $335, or $90 per day. **Contact:** Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, University of Michigan, Ann Arbor 48109 (313) 764-2287. **Approved for:** 20 hours of Category I Credit.

Date: July 7-8, Wayne State University Symposium on Cerebral Resuscitation. Location: Westin Hotel, Detroit. **Sponsor:** Wayne State University School of Medicine. **Contact:** Gerald Prieur, Division of Continuing Medical Education, (313) 577-1180. **Approved for:** 12 hours of Category I Credit.

Date: July 11-14, Advances in Emergency Care. Location: Grand Traverse Hilton, Acme. **Sponsor:** Michigan Chapter, American College of Emergency Physicians. **For:** Emergency physicians. **Cost:** ACEP member: $100, Non-ACEP member: $300 for 4 days attendance. **Contact:** ACEP, 1305 Abbott Road, Suite 109, East Lansing 48823. **Approved for:** 30 hours of Category I Credit.

Date: July 22-25, Fourteenth Annual Summer Conference — Update for General Practice Ophthalmologists. Location: Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Cost:** $150. **Contact:** Leslie E. Meissner, MOS Administrative Assistant, (313) 839-3011. **Approved for:** 8 hours of Category I Credit.

Date: July 22-26, Intermediate Course on Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: July 29-30, Sixty-Second Annual Coller Penberthy Thirlby Medical Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center Continuing Education. **Cost:** $50. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, Traverse City 49684 (616) 947-6140, Ext. 146. **Approved for:** 9 hours of Category I Credit.

Date: July 30-Aug. 1, Arrhythmias and Cardiac Ischemia: Diagnosis and Management. Location: Boyne Mountain Resort, Boyne City. **Sponsor:** International Medical Education Corporation. **For:** Physicians, nurses and technicians. **Cost:** Physicians — $245, Nurses and technicians — $130. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, 64 Inverness Drive East, Englewood, CO 80112 (303) 773-1144 or 800-525-8646. **Approved for:** 13 hours of Category I Credit.

Continued on page 342

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CATEGORY I/Continued

Date: August 21, Ethics, The Law, and Medicine: Who's in Charge Here? Location: Fairlane Manor, Dearborn. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $95. **Contact:** Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, University of Michigan, Ann Arbor 48109. (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: Aug. 23-27, Tutorial on Direct Action Thrusting. Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: August 28-29, Anatomy and Techniques of Regional Anesthesia. Location: Gordon Scott Hall, Wayne State University School of Medicine. **Sponsor:** WSU Division of CME. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, 9B DRHUHC, Detroit 48210 (313) 577-1180. **Approved for:** 12 hours of Category I Credit.

Date: September 8-9, 1982 Western Michigan Trauma and Critical Care Symposium. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Butterworth Surgical Education and Nursing Departments. **Cost:** $75 for two days or $45 for one day. **Contact:** Beth DeVriendt, Butterworth Hospital, (616) 774-1405. **Approved for:** 12 hours of Category I Credit.

Date: September 9-11, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, Chairman, 290 Blodgett Professional Building, 1900 Wealthy St., SE, Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Sept. 10, "Seventh Annual Cardiac Rehabilitation and Exercise Testing Symposium." Location: Borgess Medical Center, 1521 Gull Road, Kalamazoo. **Sponsor:** Borgess Medical Center/Southwestern Michigan Area Health Education Center. **Cost:** $65. **Contact:** Laura Denman, MS, Cardiac Rehabilitation Institute, Borgess Medical Center, Kalamazoo, 49001 (616) 383-8342. **Approved for:** 7 hours of Category I Credit.

Date: September 10-12, Fifth Annual Court in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Department of Radiology and Department of Postgraduate Medicine and Health Professions Education, The University of Michigan Medical School. **For:** all interested physicians. **Cost:** $275. **Contact:** David Bruce Youel, MD, Director, Office of Continuing Medical Education, Towsley Center, U-M Medical Center, Ann Arbor 48109 (313) 763-1423. **Approved for:** 16 hours of Category I Credit.

Date: September 24-26, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: October 13, First Kalamazoo Vascular Symposium. Location: Kalamazoo Hilton Inn. **Co-sponsor:** Regional Vascular Surgery, PC and Southwestern Michigan Area Health Education Center. **Contact:** Charles L. Zeller, Jr., M.D., Director, Continuing Medical Education, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo, 49001. (616) 388-7877. **Approved for:** 5-6 hours of Category I Credit.

Date: Oct. 14-17, Annual Regional Meeting of the Michigan Chapter, American College of Physicians. Location: Traverse City Hilton. **Sponsor:** American College of Physicians, in association with the Michigan Society of Internal Medicine. **Contact:** Arnold R. Axelrod, MD, Sinai Hospital of Detroit, (313) 493-5780. **Approved for:** 25 hours of Category I Credit.

Date: October 15-16, Cardiac Rehabilitation. Location: Hyatt Regency Dearborn. **Sponsor:** International Medical Education Corporation. **Cost:** $245. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive East, Englewood, CO 80112 800-525-8651 or 303-740-8445, ext. 123. **Approved for:** 13 hours of Category I Credit.

Date: Oct. 25-29, Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Nov. 1-5, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Kellogg Center, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Nov. 8-10. Manual Medicine to the Extremities. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Board of Medicine Disciplinary Actions

March 13, 1982 to April 30, 1982

The following actions of the Michigan Board of Medicine were taken following investigation and appropriate administrative action, are printed from official memoranda to MSMS and are not editorialized:

• Joseph W. Rucker, MD

17300 Schaefer Road
Detroit 48235

Date, action taken
April 6, 1982
Suspended from 4-6-82 to 4-6-83

Violation
S.11(i) — A departure from or a failure to conform to minimal standards of acceptable and prevailing medical practice.

• Carol R.D. Varner, MD

2248 E. Mt. Hope
Okemos 48864

Date, action taken
April 22, 1982
Suspended from 6-21-82 to 6-21-83
3 years Probation upon reinstatement.

Violation
S.11(2) (i) — Departure from, or the failure to conform to, minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established.

• Richard Alan Jankowiak, MD

3165 Treadwell
Wayne 48184

Date, action taken
April 19, 1982
Application for Limited License for Post-Graduate Training is hereby DENIED because the record indicates an absence of good moral character.

• Milton M. Shiffman, MD

11885 E. 12 Mile Road
Warren 48093

Date, action taken
April 14, 1982
Reprimand and Limited License and a Fine in the amount of $2,000.00.

Violation
S.16221(b)(v) — Conviction of a misdemeanor or felony related to and adversely affecting the licensee's ability to practice in a safe and competent manner.
S.16221(d)(ii) — Accepted payment of travel expenses, which payment constituted kickbacks.

• Jan J. Wexler, MD

7505 Oakman Blvd.
Dearborn 48126

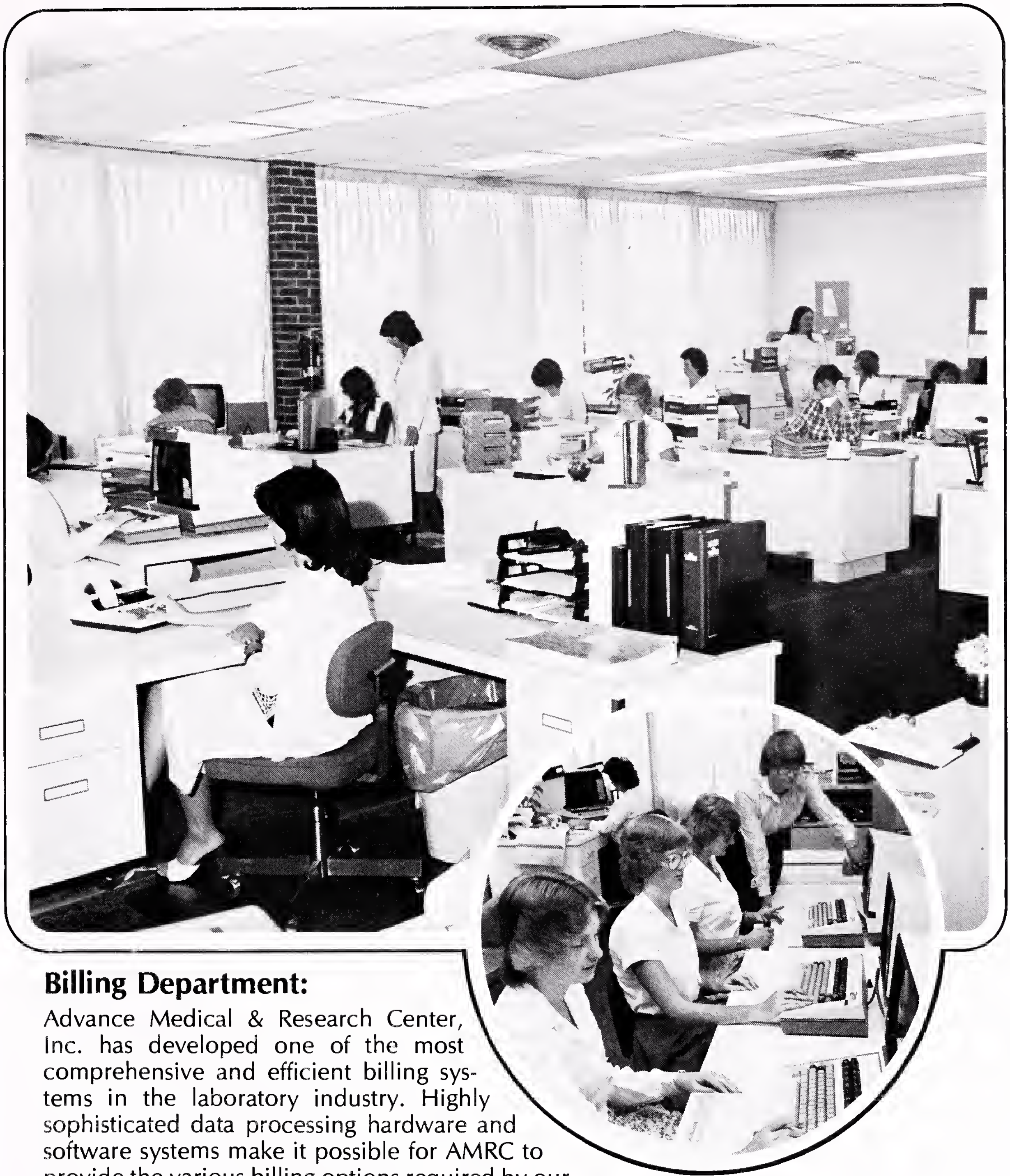
Date, action taken
April 14, 1982
Probation from 5-14-82 to 5-16-83

Violation
S.16221(c)(iv) — Prescribed a drug for other than a lawful diagnostic or therapeutic purpose.

• Jerome H. Begun, MD

P.O. Box 355
Cambridge, OH 43725

Date, action taken
April 14, 1982
License denied for lack of good moral character.



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Call Collect

The physician as a witness on the trial of a case

The following is an excerpt from a new statement of principles for physicians and lawyers just approved by the MSMS Council and the State Bar of Michigan. The statement was adopted by both groups to promote closer cooperation and a harmonious relationship. It is also seen as a step to improved patient and client relationships. For a copy of the full statement, which also covers such areas as legal uses of medical reports, physicians' compensation for legal testimony and interprofessional courtesy, please contact Nancy Wimmer at MSMS headquarters.

1. The attorney owes a duty to the physician who is to be a witness on the trial of the case to notify him as far in advance as possible as to when he is to be needed to testify and to keep him informed and advised as to any changes with respect to the time of his appearance in court as the trial develops.

2. The attorney shall notify the physician promptly of any settlement or other development during the trial of the case, such as adjournment, delay, etc., the result of which is to eliminate or postpone the calling of the physician as a witness on the trial so that the physician may have the opportunity of making other commitments for his time.

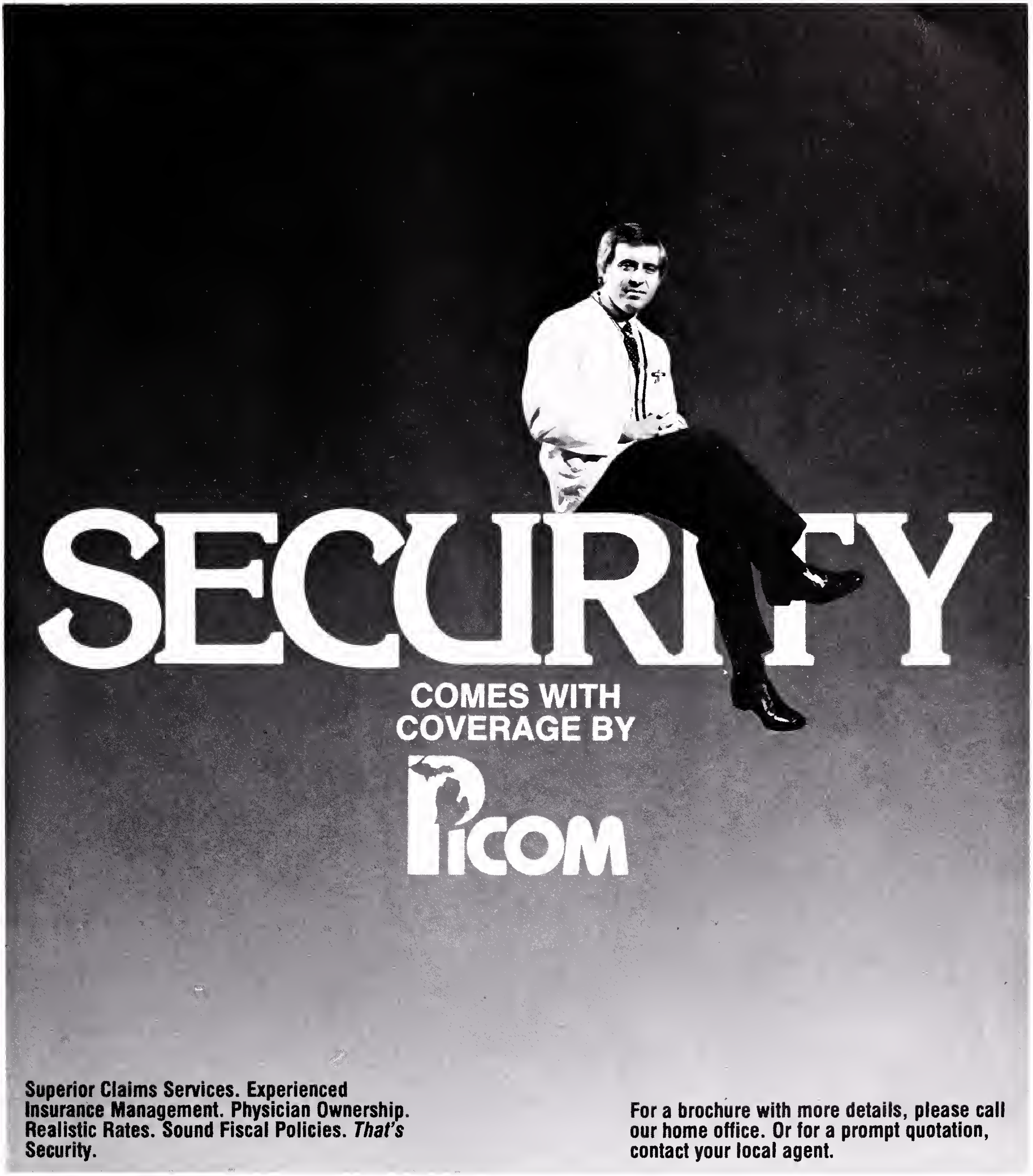
3. The attorney shall have available for the physician, when he appears as a witness, all hospital and other records which the attorney and the physician have theretofore agreed shall be at the place of trial for the physician's use. In addition, the physician shall bring office records which have been requested by the attorney.

4. The physician shall attend court at the time appointed. The attorney should appreciate, however, that a physician has continuing and often unpredictable responsibilities to his patients. Insofar as the attorney is able, he should therefore make arrangements to permit the physician to testify with a minimum of inconvenience and delay to him.

5. The physician, while testifying, should do so objectively and should answer questions as concisely and fairly as possible with a terminology where permissible which will be most understandable to a jury of laymen.

6. In giving testimony, the physician under no circumstances should permit any bias, prejudice or favoritism or personal interest to influence or affect his testimony.

7. An attorney who calls a physician to testify as an expert witness should, in advance of the physician's appearance in court, advise the physician of his intention to qualify and question him as an expert witness and should advise him as far as possible as to the nature and extent of his contemplated testimony, including the use of hypothetical questions, etc.



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Do you know

a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?

If so, please contact your MSMS Program to Assist Impaired Physicians through Marce Ireland at MSMS headquarters, (517) 337-1351.

DEATHS

Donald J. Barnes, MD
Laguna Hills, California

Donald J. Barnes, MD, formerly of Pleasant Ridge, died February 2 at the age of 86. Doctor Barnes earned his medical degree in 1920 from the University of Michigan, and in the 1930s had a radio program which focused on child care. He taught pediatrics at Wayne State University, and was a former chief of pediatrics at both Harper and Beaumont Hospitals. Doctor Barnes also was a former president of the Society of Pediatric Research and of the Detroit Pediatric Society. A fellow of the American Academy of Pediatrics, Doctor Barnes was at one time in charge of the Child Welfare Department for the Detroit Department of Health.

Richard C. Boelkins, MD
Grand Rapids

Richard C. Boelkins, MD, Grand Rapids, died March 15 at the age of 70. Former Kent County Coroner, Doctor Boelkins was on the staff of Butterworth Hospital for more than 30 years. He received his medical degree in 1937 from the University of Michigan Medical School, where he concentrated on industrial medicine. Doctor Boelkins was the first recipient of Butterworth Hospital's Edward & Susan B. Lowe Fellowship Award which recognizes outstanding young doctors, and was a Major in WWII.

Richard O. Flett, MD
Pompano Beach, FL

Richard O. Flett, MD, formerly of Saginaw, died March 14. He was 72. Doctor Flett earned his MD from Wayne State University in 1936. An emergency room physician, Doctor Flett was formerly medical director for Chevrolet's Saginaw foundries, and served in WWII as a navy medical officer.

Hugh S. Foley, MD
Dearborn

Hugh S. Foley, MD, lifelong resident of Dearborn, died April 18 at the age of 89. Doctor Foley completed his pre-medical education at the University of Michigan in 1917, then went on to Wayne State University where he earned his medical degree in 1921. He was a general practitioner. Doctor Foley retired in 1972 after 51 years of active practice.

William C. Grabb, MD
Ann Arbor

William C. Grabb, MD, Ann Arbor, died March 21 in Nassau, the Bahamas. He was 53. Doctor Grabb, an expert in the surgical repair of cleft lip and palate, was a noted author of more than 50 articles and four textbooks on plastic surgery. He won three national research awards for his scientific writings, and formerly was co-editor of the Cleft Palate Journal and associate editor of the Plastic and Reconstructive Surgery Journal. Doctor Grabb held leading positions in every national professional society of his specialty during his career, and was chairman of the examination committee of the American Board of Plastic Surgery at the time of his death. He earned his MD at the Uni-

Continued on page 348

NOW THERE IS A BETTER ALTERNATIVE TO STOOL EXAMS. ENTERO-TEST.

ENTERO-TEST® Adult, and Pediatric, a nylon line coiled inside of a gelatin capsule. The Pediatric string is 90cm and the Adult string is 140cm. Both capsules are designed to retrieve duodenal contents without intubation.

ENTERO-TEST® has the following advantages:

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- Safe
- No Radiation
- Outpatient and Inpatient Use

Studies have confirmed the following applications for the Entero-Test:

PARASITES:

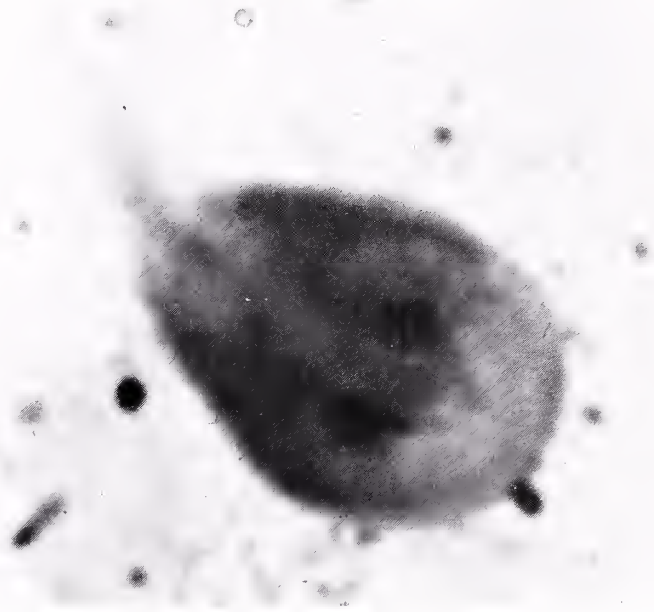
Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include Giardia lamblia (motile trophozoites), Strongyloides stercoralis (larvae and/or eggs in advanced stages of development), Clonorchis sinensis (eggs), Fasciola hepatica (eggs), Trichostrongylus orientalis (eggs), and Isospora (coccidia).

SALMONELLA TYPHI:

Multiple stool exams cultured over several weeks or duodenal intubation are the most commonly used procedures. The Entero-Test is as efficient as intubation but simpler and more comfortable. New studies have further confirmed superior applicability over other procedures.

SMALL INTESTINAL MICROFLORA (Bacterial overgrowth):

Chronic Diarrhea caused by anaerobic and aerobic bacteria in infants and children was easily identified using the Entero-Test. The string test was comparable to or better than duodenal aspirate in all cases.



Giardia lamblia

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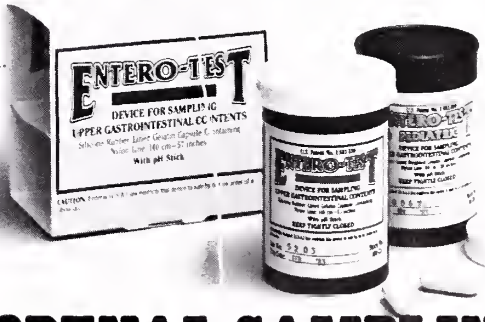

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versity of Michigan Medical School in 1953.

D. Paul Horan
Ann Arbor

D. Paul Horan, Ann Arbor, died March 29. He was 53. Doctor Horan studied general and thoracic surgery at the University of California in San Francisco, and in 1956 was awarded his medical degree. Doctor Horan had been head of the Henry Ford Hospital Division of Trauma and Emergency Surgery, and was formerly director of a resident education program for the Department of Surgery at the U-M medical center. Earlier in his career, he had been director of surgery at Wayne County General Hospital and at Walter Reed Medical Center in Washington, DC.

William S. Jones, Sr., MD
Menominee

MSMS Past President William S. Jones, Sr., MD, Menominee, died April 17 at the age of 91. Doctor Jones earned his MD from Rush Medical School in Chicago in 1915. He specialized in otolaryngology and ophthalmology, and was a pioneer in offering medical services to rural residents of the Upper Peninsula and northern Wisconsin. During those years he frequently made house calls and delivered babies. Doctor Jones retired ater 56 years of practice, at the age of 85, and in 1977 was presented the Paul Harris Fellow Award by Rotary, International for his service to youth. Doctor Jones was 1955 MSMS president, and chaired the "Big Look" committee, which directed building of MSMS headquarters. A plaque in the lobby commemorates his contributions.

Valentine L. Koran, MD
Detroit

Valentine L. Koran, MD, Detroit allergist, died March 9. He was 78. Doctor Koran earned his medical degree from Wayne State University School of Medicine in 1933, and was still practicing medicine at the time of his death. He was affiliated with St. Joseph Mercy Hospital in Detroit, and was an army Captain in WWII.

Edwin H. Lorentzen, MD
Detroit

Edwin H. Lorentzen, MD, Detroit, died April 19 at the age of 88. Doctor Lorentzen earned his medical degree in 1916 from the Detroit College of Medicine, and was a Navy medical officer stationed in London, France and Ireland during WWI. At the war's end, he was invited to Buckingham Palace to meet King George V during a ceremony honoring Britain's veterans. He worked in London as assistant chief medical officer, then returned to the US where he became affiliated with the OB Department at Mt. Sinai Hospital. Doctor Lorentzen maintained a private practice from 1924 until 1971, during which time he was affiliated with Harper Grace, Northwest and Mt. Carmel Mercy Hospitals.

Kenneth R. Magee, MD
Flint

Kenneth R. Magee, MD, Flint, died March 24. He was 55. Doctor Magee was an international authority on neurological medical science and one

Continued on page 350

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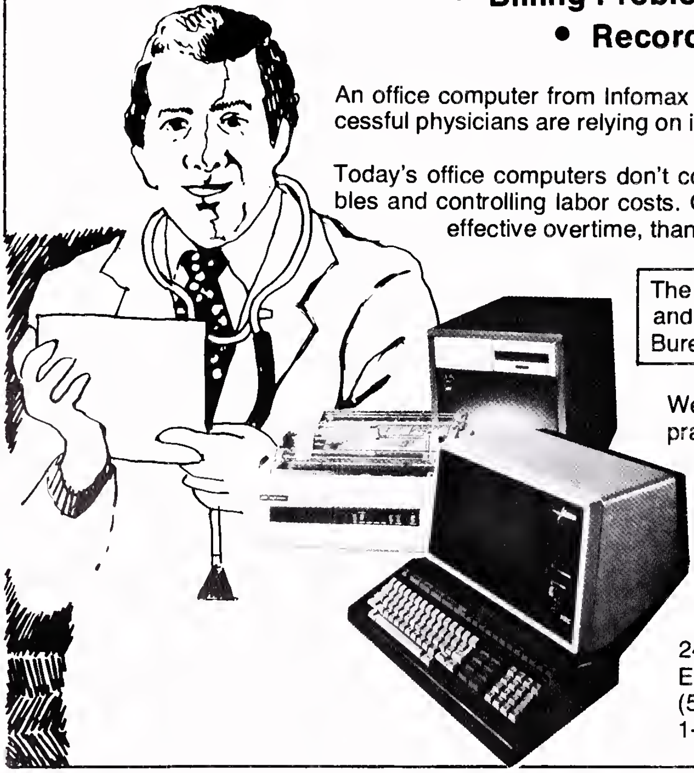

An added complication... in the treatment of bacterial bronchitis*

Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.$^{1-6}$

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note. Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

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Lilly

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200066

DEATHS/Continued

of the foremost clinical neurologists in the US. He and a colleague discovered Shy-Magee disease, a form of muscular dystrophy. He had been director of neurological education at McLaren General Hospital and professor of neurology at MSU's College of Human Medicine. He taught at the U-M medical school for 30 years, where he was named full professor in 1964. Doctor Magee was a member and advisor of Galens Honorary Medical Society at U-M, and had been named best U-M medical faculty member in 1973. A 1948 graduate of the University of Chicago Medical School, he wrote more than 100 articles and books including the popular *Freedom from Headaches*.

James J. McClendon, MD
Detroit

James J. McClendon, MD, Detroit, died April 20 at the age of 84. A civil rights activist, he played a major role in the growth of the Detroit Chapter of the National Association for the Advancement of Colored People (NAACP). Doctor McClendon was Detroit president of the NAACP for eight years, and a board member for 30 years. He earned his medical degree in 1929 from Meharry Medical College in Nashville, and during the Depression helped to establish a clinic for black tuberculosis patients. He was on the Hutzel Hospital staff for 49 years, and was president and member of the Detroit Board of Health from 1965 until 1971.

Oliver B. McGillicuddy, MD
Lansing

Oliver B. McGillicuddy, MD, Lansing, died March 29 at the age of 79. A past president of the Michigan State Medical Society, Doctor McGillicuddy earned his MD in 1925 from the University of Michigan. His patients included a governor and a concert singer, and he estimated he performed more than 40,000 tonsilectomies before his 1975 retirement. Besides serving as MSMS president from 1964-65, Doctor McGillicuddy also had been secretary, chairman of The Council, a District 2 councilor, and a delegate. He was chief of staff at E. W. Sparrow Hospital, Lansing, in 1954, and also was chief of ear, nose and throat divisions at both Sparrow and St. Lawrence hospitals. Doctor McGillicuddy was a member of the American Triological Society, Southern Michigan Triological Society, Detroit Otolaryngological Society, and the American Academy of Ophthalmology and Otolaryngology. (See related article page 318)

Edward I. Mintz, MD
Highland Beach, FL

Edward I. Mintz, MD, formerly of Detroit, died June 2, 1981. He was 76. Doctor Mintz received his medical degree from the University of Michigan in 1928, and was a Fellow in the American College of Surgeons. He was affiliated with Harper Hospital's OB/GYN Department, and was a member of Phi Delta Epsilon Medical Fraternity.

Arnold B. Newcomb, MD
Ellenton, Florida

Arnold B. Newcomb, MD, Ellenton, Florida, died February 17 at the age of 71. Doctor Newcomb, formerly of

Continued on page 352

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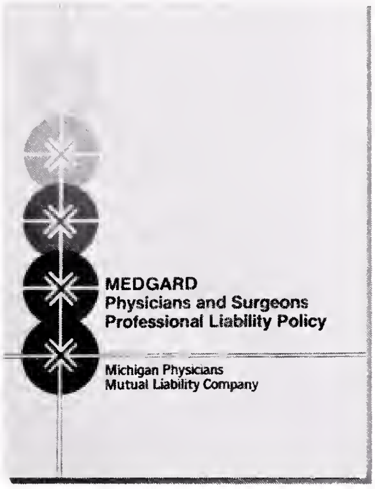
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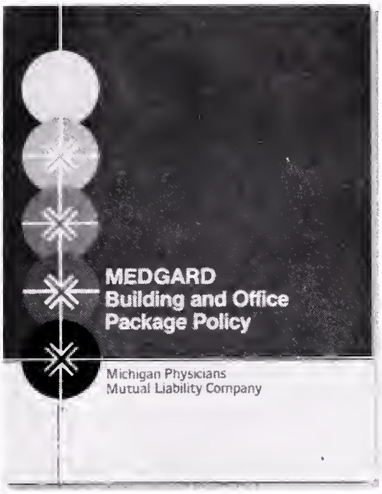
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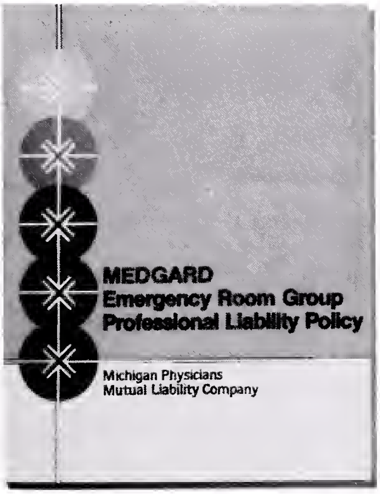
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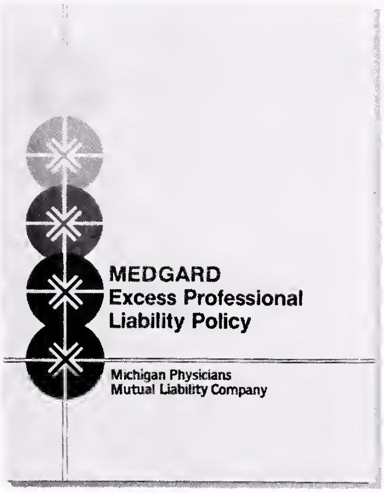
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Birmingham, received his MD from Wayne State University in 1938. He was a staff physician at Mt. Carmel Mercy Hospital, and former head of the Medical Division for Civilian Defense, City of Berkley. A general practitioner, Doctor Newcomb was a member of Phi Rho Sigma medical fraternity.

Ernest Newman, MD
Brookline, Massachusetts

Ernest Newman, MD, formerly of Detroit, died September 2, 1981 at the age of 87. He earned his MD from Tufts University in 1923, and also held a Masters of Science degree in Public Health. He maintained a general practice, and served in the United States Public Health Service during WWII.

Donald R. Nielsen, MD
Franklin

Donald R. Nielsen, MD, Franklin, died February 21, and was affiliated with Sinai Hospital and Kingwood Hospital. He served in the Army from 1945 until 1946, and was a member of the American Psychiatric Association.

Gordon J. Prout, MD
Saline

Gordon J. Prout, MD, Saline, died March 2 at the age of 76. Doctor Prout earned his medical degree from Northwestern University Medical School in 1930, then served as 1st Lieutenant in the Medical Corps Reserve from 1934 until 1941. Doctor Prout helped found Saline Community Hospital and served as its first chief of staff in 1959. He was recently honored by the hospital's board of directors with a plaque commemorating his long medical service to the community. A similar plaque hangs in the hospital lobby.

Harriet L. Shoecraft, MD
Ann Arbor

Harriet L. Shoecraft, MD, Ann Arbor, died January 30 at the age of 62. Doctor Shoecraft graduated from the University of Michigan Medical School in 1945. The Ann Arbor community benefited from her practice for 35 years until her retirement in 1979. She was a member of the Zonta Club, and Zeta Tau Alpha medical fraternity.

Karl Seitam, MD
Dearborn

Karl Seitam, MD, Dearborn, died February 17 at the age of 61. He was born in South Kopu, Estonia, and earned his MD at the Dusseldorf Academy of Medicine in 1949. He came to the United States in 1950 and did an internship at Evangelical Deaconess Hospital of Detroit. He did his residency at Indian Village Medical Center, then later became affiliated with Brent General Hospital.

Charles TenHouten, MD
Paw Paw

Charles TenHouten, MD, Paw Paw surgeon, died Oct 25, at the age of 76. Doctor TenHouten earned his MD degree from the University of Michigan Medical School in 1930. A Fellow of the International Academy of Proctology, he was a former MSMS delegate, former member of the MSMS Mediation Committee, and

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County Medical Society. Doctor TenHouten had been affiliated with Lake View Community Hospital, Paw Paw, and Bronson and Borgess Hospitals of Kalamazoo. He served in the Army Air Force from 1942 until 1946 as a lieutenant colonel, and was past president of the Village of Paw Paw.

Herman F. Van Ark, MD
Eaton Rapids

Herman F. Van Ark, MD, Eaton Rapids, died April 13. He was 68. Doctor Van Ark graduated from Marquette Medical School in 1942, where he had prepared for a general practice. He was a medical officer in Europe during WWII, and was awarded the Silver Star, Bronze Star and Purple Heart. Doctor Van Ark was formerly chief of staff at Eaton Rapids Community Hospital, and had been affiliated with Hayes-Green-Beach Hospital in Charlotte. He was past president of the Eaton County Medical Society, and the Eaton Rapids Lions Club. He retired from his medical practice in 1980.

Harry J. Winkler, Sr., MD
L'Anse

Harry J. Winkler, Sr., MD, died February 2 at the age of 87. Doctor Winkler earned his MD at the University of West Virginia in 1924, and served in World War II. He continued his medical education at the University of Cincinnati, where he specialized in surgery, and graduated cum laude. He interned at Henry Ford Hospital, then became physician for Ford Motor Company's 2000 employees at its Baraga County sawmills. After leaving Ford, he served at various times as coroner, health officer, and deputy sheriff of Baraga County while maintaining his private practice. Doctor Winkler estimated he delivered more than 4,800 babies before his retirement in 1975. He sponsored many scholarships for nurses, established student loan funds at Michigan Technological University, and started a private student aid fund. Doctor Winkler was a former president of the Upper Peninsula Medical Society, and in 1973 was awarded the Distinguished Service Award by MTU.

Alfred H. Whittaker, MD
Grosse Pointe Farms

Alfred H. Whittaker, MD, Grosse Pointe Farms, died April 13. He was 86. Doctor Whittaker was a founding partner of Detroit Memorial Hospital, and was a trustee of that institution for many years. He was past president of the Wayne County Medical Society, and was an emeritus member of the WSU Board of Governors. Listed in "Who's Who of America," Doctor Whittaker earned his MD at Ohio State University in 1918, and was a 1st Lieutenant in the US Army during WWI. He was past president of the Medical Alumni Association of Ohio State, the American Association of Industrial Physicians and Surgeons, and the Detroit Historial Society. In addition, Doctor Whittaker was a member of the Board of Directors and Executive Committee of the Detroit Chapter of the American Red Cross.

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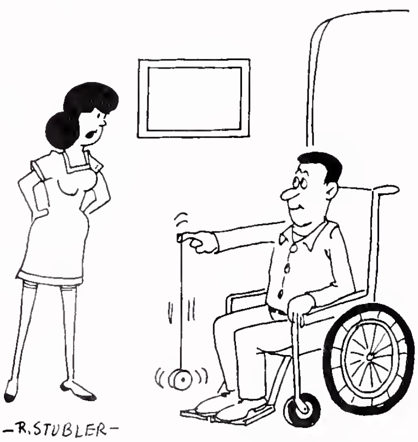

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DETROIT AREA: Looking for career-oriented Emergency Physician Board Eligible or Certified in Emergency Medicine, Internal Medicine, Surgery, or Family Practice. Directorships with stipends available. Excellent compensation including malpractice. Contact: Becky Boehlke, Emergency Consultants, Inc., 13 West Big Beaver, Troy, Michigan 48084; (313) 649-5710/5711.

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MICHIGAN, LANSING: Full time Emergency Physician wanted to complete five man group at 280 bed hospital. Fee for service with EXCELLENT remuneration. Contact Director, Emergency Department, St. Lawrence Hospital, 1210 W. Saginaw, Lansing, MI 48915. (517) 337-0304.

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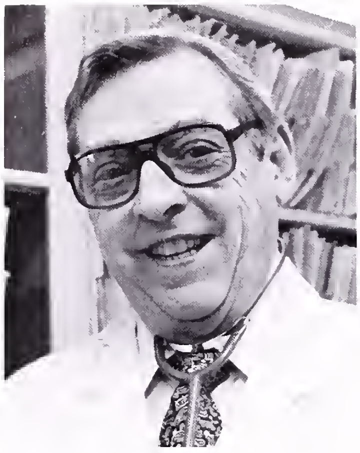

We would be wise not to ignore public's complaints

By James. H. Tisdel, MD
MSMS President

Doctor Tisdel's initial president's page article is excerpted from his inaugural address delivered at the 1982 MSMS House of Delegates meeting May 1.

My role as President of this society will be that of spokesman. I will devote my time and energies to work for the implementation of the policies of this House. I will work diligently with The Council. I hope to travel throughout the state visiting component societies and MSMS sponsored functions. My responsibilities will be to the individual members, to get to know as many as possible by attending their meetings.

I intend to work in full cooperation with our Council and our Council Chairman. I fully endorse the programs already started by MSMS in recent months. Bringing the county society leaders, chiefs of hospital staffs and committee chairmen together in recent meetings for briefings about MSMS plans and programs is a vitally needed step — one which I hope we can continue in the coming months. Only through clear and close communications with our members can we hope to gain acceptance of our programs.

I shall endeavor to continue the work of my predecessors, especially on those programs of humanitarianism and professionalism they've initiated. My policy will be the continuity of established activities, meeting needs as they arise.

I will not catalogue our problems and suggested solutions. The members of this medical society can readily sense them. Rather, I would like to make some personal comments about medical practice and philosophy as I view them based upon my experiences since I started as a medical student 39 years ago.

My teaching was like all Gaul — medicine was (and is) divided into three parts — the Art, the Science and the Business. It is not of the science or business aspects that I wish to speak. We all know that science and its technology and knowledge are racing ahead — far ahead of our much more slowly developing wisdom. In just the last 15 years scientific research and technological advances have been so rapid and successful that they have produced roughly 60 to 70 percent of today's armamentarium for the prevention, detection and treatment of accidents and disease. The science is mighty and growing daily — but what about the wisdom needed for proper implementation in the healing of the sick?

Fifteen years ago a Harris poll reported that 73 percent of the American people had "a great deal of confidence in their physicians." A recent Harris poll reported that now 37 percent of people have great confidence in physicians. What has happened? The fact that Harris and other pollsters report doctors still rank highest among business and professions is small consolation when two thirds of the people polled denied a great deal of confidence in their doctors.

What a paradox — at a time when we provide the highest quality and distribution of care ever enjoyed by any people, anywhere, at any time — at a time when for 20 straight years we have lowered infant mortality over the previous year — at a time when the record shows a marked lowering of the death rate from heart disease and stroke — at a time when our senior citizen population is expanding at a greater rate than any other — living longer and better — at such a time, public confidence in physicians has reached an all-time low . . .

Why is this so? Our great science and technology has been politicized. We are attacked by the media. Many politicians, labor leaders and some in business and industry are adversely critical. And we, as physicians, are not blameless. Much loss of confidence we have brought upon ourselves. This overall negativism toward doctors is not because of a lack of technical skill — but, I suggest, is because of a lack of such human attributes as kindness, concern, tolerance and understanding of patients and their feelings and fears. We would be wise as physicians not to ignore the importance of these public complaints.

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Also for the treatment of documented ***Pneumocystis carinii*** **pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.**

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia *Allergic reactions.* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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DOUBLE STRENGTH TABLETS

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*due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

MICHIGAN MEDICINE

July 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 81, No. 33

Meeting
humanity's
needs

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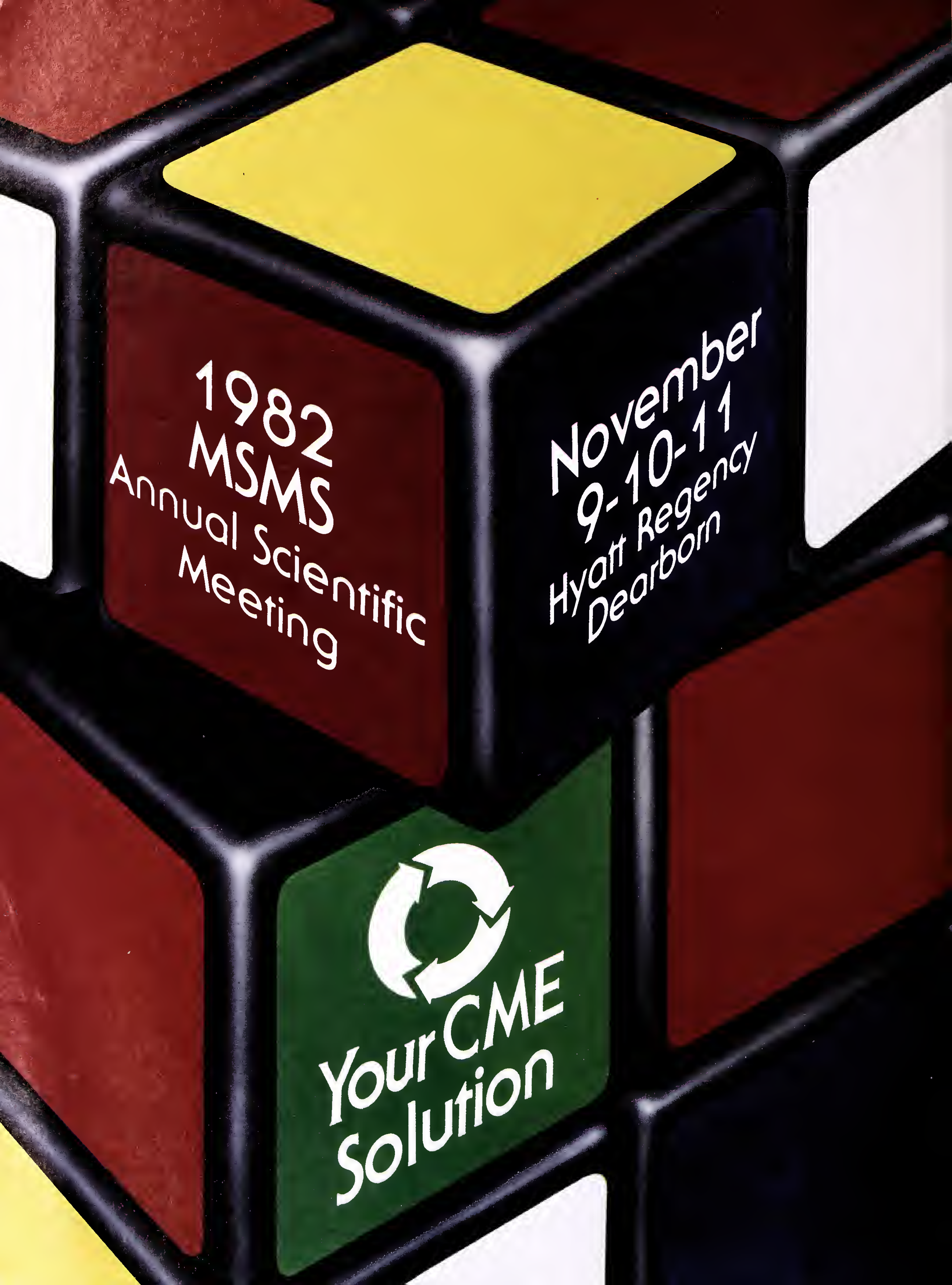
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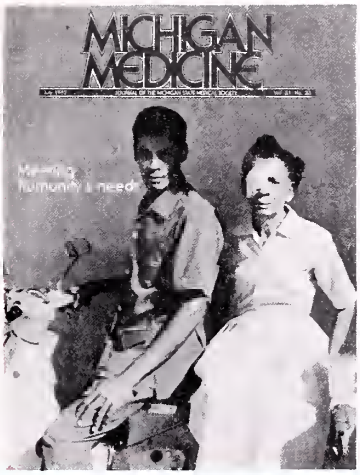


Cataract surgery over, a Honduran woman gets a ride home on a motorbike. Her surgery was done by Michigan physicians serving working vacations in her village. Their work is described in this month's special report on physicians' humanitarian service. **(Photo supplied by Fleming Barbour, MD, Flint)**

MICHIGAN MEDICINE
July 1982, Volume 81, No. 33

Special report

362 This month *Michigan Medicine* begins a two-part series on the Michigan doctors who work to meet humanity's needs for little or no remuneration. James H. Tisdel, MD; Kenneth J. Ray, MD; Fleming A. Barbour, MD; Martha Climo, and Willah Weddon.
Next Month: Spotlight on World Medical Relief, Inc., Detroit

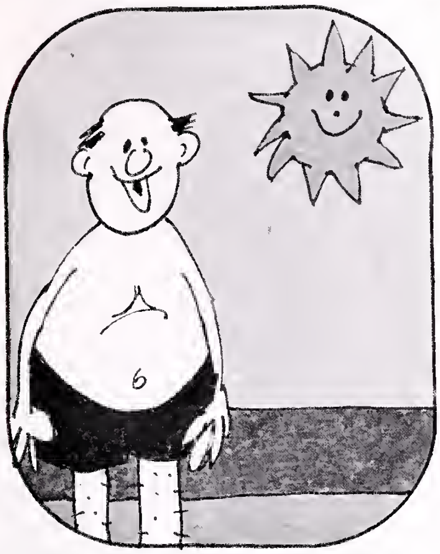
Features

373 Meeting the challenge of the 80s: Planning for retirement in the midst of economic ferment
378 Michigan's unique genetic services program; Susan Letwin
380 Preview of the 1982 MSMS Annual Scientific Meeting
382 Photo feature on MSMS women physicians' conference
395 Photo highlights of the 1982 MSMS House of Delegates meeting

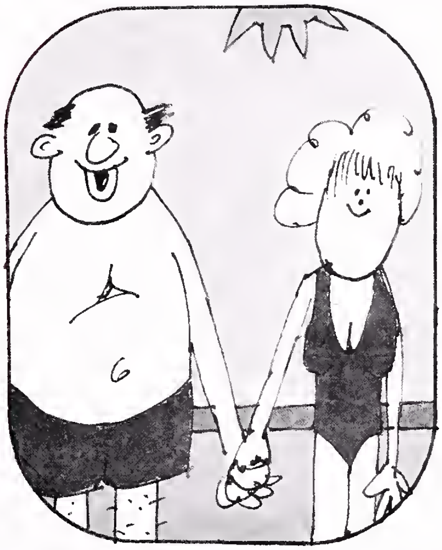
Departments

358 MSMS officers
359 Letters
381 News
383 Views; Charles E. Payne, MD; Richard W. Hodgman, MD; Cecil R. Jonas, MD
402 New members
412 Category I courses
416 Meetings
418 Deaths
420 Classified ads
422 President's page; James H. Tisdel, MD

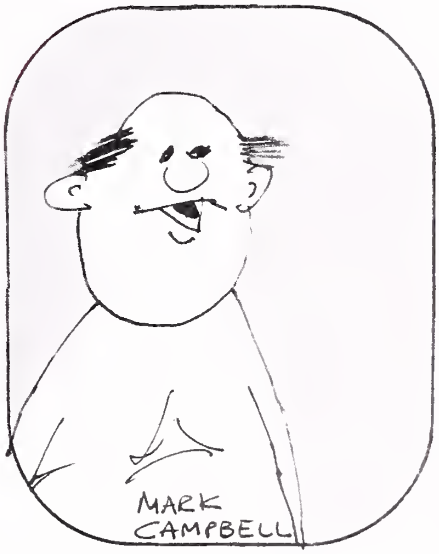
Doctor Quick-Draw



Continuing Medical Education is expensive and time consuming.



I've checked in; visited the hospitality suites; and gone on all the sightseeing trips . . .



. . . Now where do I get my C.M.E. card validated?

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Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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1866

LETTERS

Thank you from medical assistants

It is my sincere pleasure to advise you that the following resolutions were approved by the House of Delegates of the American Association of Medical Assistants, Inc, State of Michigan, at the 32nd Annual Meeting on April 29-May 1 in Jackson.

Whereas:

The Michigan State Medical Society has given moral and financial support to this Society in such areas as printing and mailing of our House of Delegates Packet and Directory; mailing of the Professional Medical Assistant Junior; printing and mailing state seminar notices; and granting us the privilege of using their Lansing headquarters, be it

Resolved,

That we express our sincere thanks.

Whereas:

The Michigan State Medical Society invited this Society to participate at the Annual Scientific Meeting in Dearborn in November 1981, be it

Resolved

That we express our sincere thanks.

We are grateful and appreciative of your continued interest and support.

Ann E. Phillips, CMA
Resolutions Chairman

Margaret Gray, CMA-C
President
East Lansing

Again, thank you to House of Delegates

The following letters were received recently by MSMS secretary Robert M. Leitch, MD.

We were honored to receive recognition by the Michigan State Medical Society and to be presented with an MSMS Presidential Citation on April 30.

Please forgive our delay in thanking you and the Society for this award. We have been knee deep in gathering, packing and shipping two 40 foot containers for Poland. On May 4 the first 40 foot container left our warehouse loaded to the brim with medicine, equipment and supplies valued at $2,554,956.50 and weighing 37,533 pounds. On May 10 the second 40 foot container left equally loaded and weighing 34, 360 pounds valued at $1,427,543.06.

The plight of the Polish people has touched the hearts of many here in the United States. Reports have come to us that their hospitals are having to wash used dressings and that they are without medication and soap. We just hope and pray that the shipment that is on its way will arrive safely and get into the hospitals it is intended for.

Again, we thank you for honoring World Medical Relief with such an award, and for your continued faith and support in our organization.

Irene M. Auberlin
President
World Medical Relief, Inc.
Detroit

On behalf of the medical student section I would like to thank the speaker of the MSMS House of Delegates, and colleagues for a very enjoyable, educational and interesting weekend. We felt very welcome and were pleased with the attention and concern that our resolutions and opinions were given.

It was encouraging and comforting to me to speak with long-time physicians who shared the same ideals and concerns about health care and the future of medicine as we medical students do.

Hopefully the medical student section will become an increasingly viable and hard working unit of the Michigan State Medical Society.

Mark R. McMurray
MSU-CHM Delegate
East Lansing

I am writing to you as secretary with the expectation that you will pass on to the officers and involved staff, my deep appreciation for the way the celebration of my 50 years in practice was handled by the Michigan State Medical Society. I cannot speak for the others, but my opinion is that what I am saying would be endorsed by all the honorees 100 percent.

Again, thank you.

Kenneth H. Johnson, MD
Lansing
MSMS Past President
and Secretary

Doctor Raven

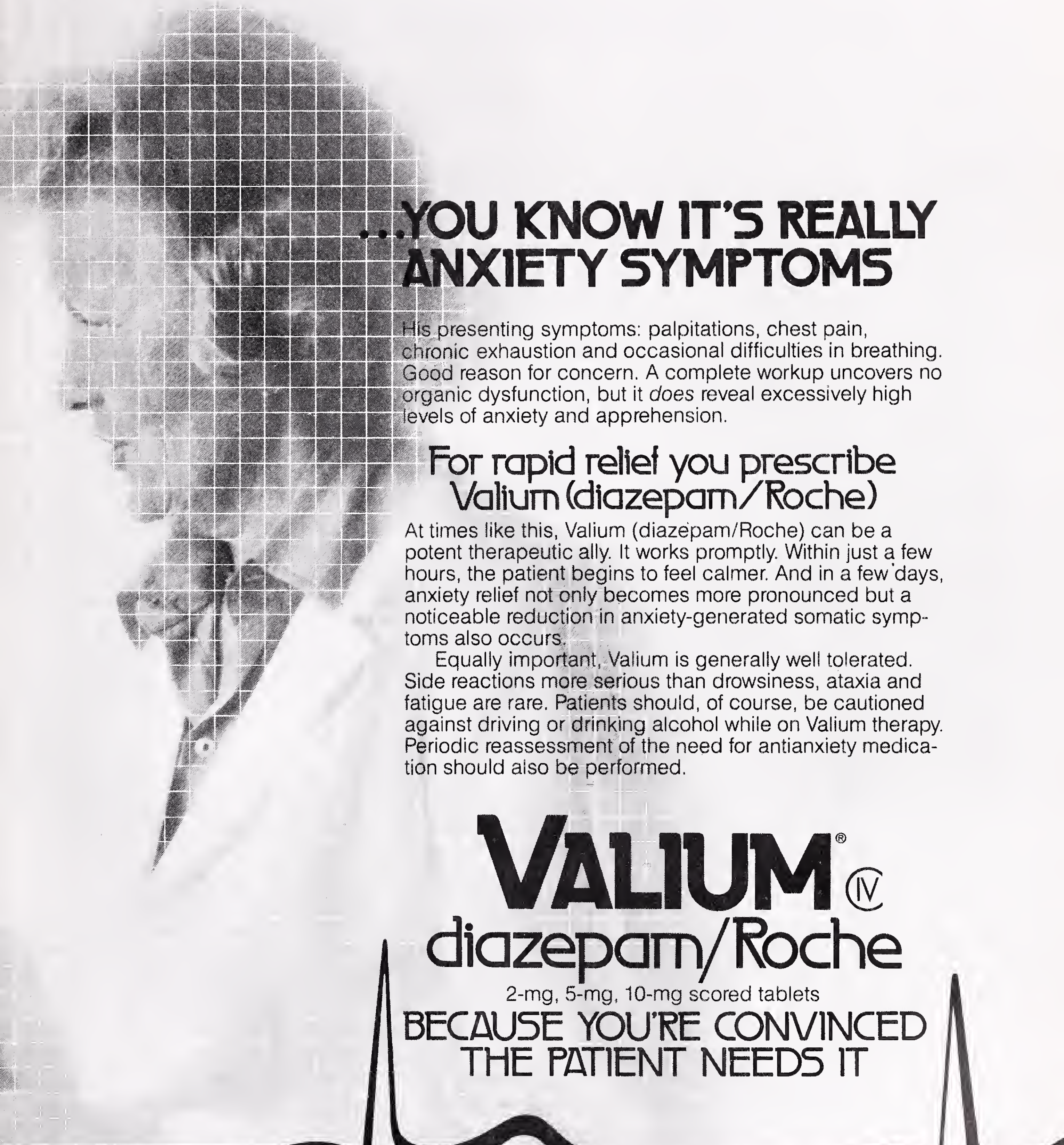
It is with sincere appreciation that I have learned that Clara Raven, MD, is being recognized by Michigan State Medical Society for her contribution as president of the Michigan Chapter, American Medical Writers Association.

May I also commend Doctor Raven for her years of research on sudden infant death syndrome (SIDS), her counseling and guidance of bereaved families, her leadership in promoting the work of the Michigan Sudden Infant Death Study Association which later became a chapter of the National Foundation for Sudden Infant Death, Inc., and for her work in helping to establish the Michigan Chapter of the International Guild for Infant Survival, Inc.

Doctor Raven is, indeed, a woman of valor; and the recognition of her scientific achievements is to be commended. It is to be hoped that she will be blessed with good health and will continue her valuable work for many years to come.

Fanyerose G. Cullinan
Attorney at law
Youngstown, Ohio

THE PATIENT THINKS
HE HAS HEART TROUBLE...



...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

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At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

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diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

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VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500,* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

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Special report

Doctors do care!

Join with us this month in celebration of the many Michigan physicians who work unselfishly for the good of humankind. They are the good doctors who work in the mission fields, who organize to be sure newly-unemployed auto workers don't lose out on medical care because they can't afford it; who work to raise the public's consciousness to the horrible consequences of nuclear war, in hopes of preventing it; who counter Madison avenue's slick pitch for unhealthy lifestyles with their own equally clever appeal for good health habits.

You must be as tired as we are in MSMS offices of hearing that physicians care only for their pocketbooks. We know that isn't true. The problem is, many of those who care the most are unsung. They don't work for publicity; they work to help others. And their story doesn't get told.

We are telling the stories mentioned above in this issue, because we believe physicians need more of this good publicity. We lead off with MSMS President James H. Tisdel's account of the forming of his new MSMS Committee on Humanitarian Service. Doctor Tisdel is leading an MSMS birth of recognition, of the need for more compassionate service on behalf of the needy, and of the many humanitarian services already being performed by Michigan physicians. It is a cause Doctor Tisdel believes in deeply.

In our August issue, we will spotlight the remarkable organization, World Medical Relief, and its inspiring chief, Mrs. Irene (L.G.) Auberlin, of Detroit. WMR has been designated the first official project for support and promotion by the MSMS Committee on Humanitarian Service. WMR is worthy of that support, as you will learn in that issue.

Join us in saying, not just that "Doctors Ought to Care," but "Doctors Do Care!"

Humanitarian service needed today more than ever

By James H. Tisdel, MD
Port Huron

There are many rewards and joys of being members of the medical profession. But the opportunity for service to our needy, young and old, the chance to give kindness and to offer help — these have to be the most rewarding.

It is in this spirit that the MSMS Committee on Humanitarian Services was formed, the result of the effort and thought of John R. Ylvisaker, MD, MSMS president 1980-81. The MSMS Council created the Humanitarian Services committee in July, 1981. In his presidential address in May that year, Doctor Ylvisaker highlighted standards of professionalism and humanitarianism as goals worthy of this organization. The Council, with Doctor Ylvisaker's backing, stated that this committee was to identify areas where MSMS could use its influence to bring about improvements in the public's health at the state, national, or international level.

A second purpose was to increase public awareness of the many humanitarian services with which members of organized medicine already are involved. The original committee, as appointed by the Council chairman, consisted of myself as chairman; Doctor Ylvisaker, MD, and Brooker L. Masters, MD, also a former president of MSMS. It is now one year after the appointment of the above committee and we have added some members of our auxiliary: Mrs. Cheri Calvelo, MSMS/A president, 1982-83, and Mrs. Betty Drew, president-elect. These women, I feel, will add dimensions of thoughtfulness and wisdom as we continue to work to fulfill the purposes of our committee.

Our staff representative from the beginning has been Dennis Paradis. His work and grasp of our purpose have been excellent. Mr. Paradis must receive much of the credit for any success we have accomplished or will attain.

Doctor Tisdel is MSMS president and chairman of the MSMS Committee on Humanitarian Services.

Down to work

The major activities of the committee have been to host a discussion between the director of the National Health Service Corps and the Michigan Departments of Budget, Mental Health, Corrections and Public Health to explore the maximum use of the National Health Service Corps physicians in Michigan. This meeting was chaired by Maurice Reizen, MD, and already has had a positive increase in physician coverage in our prison system, as the Michigan Department of Corrections has become eligible for additional National Service Corps personnel.

The committee also investigated and made a recommendation that MSMS use its publications to inform physicians about the work of World Medical Relief, Inc., a Michigan based international relief agency. This exposure, we hope, will aid World Medical Relief in obtaining medical supplies to be shipped to developing countries around the world.

I cannot refer to World Medical Relief without mentioning the uplifting experience we received from a visit to this organization in April, 1982. It is unfortunate that each and every physician in Michigan cannot visit World Medical Relief and its personnel. It also is unfortunate that all government relief agencies and their personnel cannot do the work accomplished by this group on such little financial backing. We can all learn from World Medical Relief.

I also must mention that its director, Mrs. Irene Auberlin, was the recipient of a Presidential Citation from 1981-82 MSMS President James Fryfogle, MD, at our House of Delegates meeting April 30, 1982. No one is more deserving of our award than Mrs. Auberlin and the wonderful group of workers and volunteers she heads at World Medical Relief. This committee will continue to use the influence of MSMS to help World Medical Relief obtain medicine and supplies in any way we can. It will be an honor and a great pleasure to continue our association.

Young and old

The Humanitarian Service Committee also is working with other agencies on programs to keep health records on senior citizens up to date and available in case of emergencies, e.g. the Vial of Life and Passport to Good Health Care programs.

We also are planning to begin work on the problem of child abuse. At our last meeting we heard from Douglas Sargent, MD, chairman of the AMA Committee on Child Abuse. He outlined ways that the Humanitarian Service Committee may be able to aid the national program on this serious problem. Child abuse will be our chief endeavor for the coming months, and one that all committee members are interested in and want to get started.

This committee will continue and grow because what it stands for is needed today more than ever. The physicians of Michigan, by the nature of the profession, render humanitarian services every day. This committee hopes to focus on the works and service that MSMS members give to let all citizens know we care.

Unemployed fall out of the system, but downriver Detroit physicians help

By Kenneth J. Ray, MD
Trenton

About two and a half years ago, it became evident that the Detroit metropolitan area was in a serious economic decline. Nowhere was this more evident, however, than in the downriver area, south of downtown Detroit along the Detroit River. The downriver area is comprised of 17 townships and cities, including River Rouge, Ecorse, Wyandotte, Trenton, Riverview, Melvindale, Allen Park, Lincoln Park, Taylor and Flat Rock.

The time frame is important here, because this evidence of decline preceded President Reagan's economic policies by a substantial period of time.

Plant closings and soaring unemployment in the auto industry were creating a new class of poor. These people, who had been the backbone of their communities, suddenly were faced with a loss of income. Many of them owned their own homes and automobiles and did not qualify for the traditional public assistance programs.

There was a growing concern that many of the unemployed would be neglecting their health care, particularly as their health insurance benefits expired.

To respond to their needs, the Great Detroit Area Hospital Council, in cooperation with the Wayne County Medical Society, the Wayne County Osteopathic Society and downriver hospitals organized Project Health Care.

The initial response of both allopathic and osteopathic physicians was gratifying. Fifty-eight physicians volunteered to provide from one to 10 office visits per week. All the downriver hospitals agreed to provide their services at no cost should hospitalizations be indicated. In addition, many consultants since have provided services to hospital patients although they were not part of the original volunteer enrollment.

Fortunately, there already was a facility which could be used as a referral and screening center.

When the downriver economy began to deteriorate, the communities in that area formed the Downriver Communities Conference to improve the local economy. They were willing to serve as a referral source and to provide some simpler screening to determine eligibility according to guidelines which had been established.

As this program developed there was some concern that demand would exceed capacity. To date, this has not occurred, and it appears that existing resources are sufficient to meet anticipated needs.

The physicians involved in this program have not been overburdened. For most of us it has been a simple matter to fit the new referrals into the day's schedule, particularly as regular appointments have generally been greatly reduced due to the severe economic straits of our state's citizens. In the practical economics of office practice, no additional costs are incurred in this process. Some of the physicians make no charges. Others prefer to charge a token fee of two dollars per visit.

After a little over a year of experience, there is still some concern as to how well the program has helped the target population. There is an impression that more of the chronic poor have filtered into the program than was originally intended. On the other hand, there is some uncertainty as to whether the new poor are being adequately cared for.

Unfortunately, there is no adequate means to assess penetration of the targeted population, nor is there an accurate method to determine unmet needs. The unemployed seem to fall out of the system. Local unions have cooperated with this program, but the unemployed often lose contact with their own unions.

Additional publicity for this program was provided through the local media. In spite of their efforts, there is every likelihood that many of those who qualify for this program are not taking advantage of it. The man who has worked all his life and paid his own way is usually a proud man. When his income is cut off, he is reluctant to accept help.

Currently, the Greater Detroit Area Hospital Council staff is working to expand this program into other areas of metropolitan Detroit.

There is no doubt that the need exists, and when the opportunity appears, physicians certainly will respond in the best tradition of medicine.

Doctor Ray is a family physician, an MSMS Councilor, and a founding member of the Downriver Detroit Project Health Care.

Patients begin lining up at 5 AM for ophthalmologic clinic.

Try a working vacation, through Medical Group Mission to the needy

By Fleming A. Barbour, MD
Flint

How would you like to spend two weeks in a Central American country, using your medical skills to help people who otherwise might never see a doctor?

Doctor Barbour is a Flint ophthalmologist and has been on 12 medical missions to underdeveloped countries. He is chairman of the board of Mott Children's Health Center, member of University of Michigan Developmental Council, and immediate past president of the university of Michigan Medical Center Alumni Association.

You can — and your family may be part of the non-medical personnel involved in clerical work or patient traffic control. Many MSMS members already have made one or more mission trips and frankly say it was one of the great experiences of their lives.

Interested doctors often ask, "Who started all this?" The great and widespread need for medical help in third world countries is well known. In the mid-1960s members of the Christian Medical Society responded to a request for help from a doctor in Honduras.

They founded the Medical Group Mission projects. Several principles of operation were established:

1) An official governmental invitation is needed to start a project.

2) All missions are short term — approximately two weeks — with a strong emphasis on repeating the program in the following year.

3) Cooperation plus a teaching experience with local doctors is to be encouraged.

4) Local cooperating committees are important — church groups, civic groups, Red Cross.

5) Interfaith approach to the total person is a special goal.

6) Participation is open to any interested person — (practically every US state and Canadian province has been represented since the program started).

A wide variety of project locations and dates now are offered. In 1982, projects are planned in Honduras, Dominican Republic, Haiti, Nicaragua and India. Guatemala,

Doctor Barbour examining eye patient attended by native nurse.

Taiwan and Columbia have been included in previous years.

An MGM sponsored trip is planned for most every month of the year, which offers the participants a broad selection.

In Lberia and Kenya, MGM doctors also have lectured for CMA credit to missionary doctors who could not return to the United States for instruction.

One starts by requesting an application from MGM headquarters. MGM is self supporting. Participants pay all their own expenses including MGM registration fee and air fare. The participation fees are the major source of income for the program, and cover administration costs, accommodations, drugs, supplies, food and local transportation (bus, air or train to the outlying projects).

Registration fee	$50
Project fee	$250 - two weeks $175 - 10 days
Air fare:	
Miami-Honduras-Miami	$225
New Orleans-Honduras-New Orleans	$225
Michigan-Miami-Michigan	$250-$300
Michigan-New Orleans-Michigan	$250-$300

All these fees and expenses are paid through MGM and are tax deductible.

One of the special reasons MGM programs are so successful and accomplish so much are the highly competent staff members — John Shannon and Willy Hunter in the Dominican Republic and LaMar Stauffer and Lois Comstock in the USA. They manage all the details so the doctors can spend their time taking care of people.

To give the reader an idea of what goes on, here is an outline of our most recent mission, to LaCeiba, Honduras.

Our group left New Orleans and Miami on Saturday and arrived in LaCeiba after a one and one-half hour flight via TAN Airline. Custom and baggage checks were expedited by the local chairman, Miguel Kawas. Room assignments were made and the rest of the day was spent organizing village teams, getting acquainted with the host family, packing medicines and getting accustomed to the climate change.

At dinner we have our first chance to meet the entire group of these wonderfully dedicated people. The village teams were formed consisting of doctors, nurses, dentists, translators and non-medical personnel helpers. Specialists were assigned to the two city hospitals — Atlantida and D'Antona, and to the city Red Cross clinic. Surgery was done at the above hospitals, except the eye surgery which was done at a local private ophthalmology clinic. The physician there, Doctor Ponce, gave up two weeks of his operating time because of his strong support of the program.

Breakfast was at 6:30 am. Buses left for the villages where clinics are set up in a church, schoolhouse or local health clinic. These are villages where the only medical service might be a public health nurse. Some teams went by airplane over the mountain or to remote areas of the eastern jungle. Five hundred to 700 people usually were seen in a day. Patients who could afford to paid a small fee. Patients needing surgery were referred to LaCeiba.

Dinner was at 6 pm when the work was done. Most people were ready for bed early. Evenings also were spent packing medicines, sightseeing in town or talking with the host family. Several local restaurants offered excellent food, especially "conch chowder." Money exchange was easy, as two limpiras equal one dollar; US money is freely accepted. The weekend offered a charter flight on Saturday to see the famous ancient ruins of Copan. Sunday a picnic was planned using the old Standard Fruit Company train to travel about 30 miles to a fine beach.

Thus, we had a "working vacation!"

In the 1982 LaCeiba project 139 volunteers from the USA and Canada took advantage of this MGM opportunity to help where help is so desperately needed.

During that project in March, eight ophthalmologists saw 2,500 patients in five different locations, dispensed 2,100 pair of discarded eye glasses collected in the USA and Canada and did 209 surgical eye procedures.

Used eye glasses are collected by the thousands from all over the USA and Canada. They are repaired, sorted, graded, packaged and shipped to be used in the projects. Collecting discarded glasses has been one of the projects of the Michigan State Medical Society Auxiliary.

Several of the doctors last March were fortunate enough to be part of a unique experience. To reach an isolated village a team traveled by bus for one and one-half hours, stopped at a railroad crossing where the team and their supplies were loaded on handcars and pushed by natives about five miles to a river. Then they were loaded into big dugout canoes made from a single log and canoed downstream through a tropical wilderness to reach a native village on the ocean. After two busy clinic days they returned by the same route — the team captain said the gratitude of the village was overwhelming!

Another team was flown over the mountains by mission plane to a refugee camp at Nacaron, where over 6,000 Misquito Indians — driven out of Nicaragua — desperately needed medical attention.

MGM has been well supported by MSMS members. After a number

A typical Honduran village where clinics are held.

of years as team leader for Ophthalmology in LaCeiba the writer turned the job over to Arthur Wierenga, MD, of Jackson. Don May, MD, of Kalamazoo is now the assistant director for the entire LaCeiba project. Marvin Jewell, MD, of Detroit has been a team leader of a Liberian project. There is no end to the need for our services.

In a "thank-you" letter the Nicaraguan Society of Ophthalmology wrote in part after the July, 1981 mission, " . . . to express to you our feelings for the magnificent, humanitarian and efficient scientific and social work you accomplished in our country: Attitudes like yours, inspired in noble feelings of solidarity, are a motive of great satisfaction to us. We also take the opportunity to manifest our appreciation for the teachings we acquired from you and the opportunity we had to interchange experiences."

There is great personal satisfaction in giving your skills, your time and your money. In addition there is an atmosphere of deep spiritual faith which undergirds the project and gives an additional dimension to the work.

Try a working vacation — there are no medicare, medicaid, Blues, HMOs, HHS or malpractice to worry about; only sick people who need your help and are grateful beyond measure!

For further information:
Medical Group Mission
Christian Medical Society
1616 Gateway
Richardson, Texas 75080
Phone: 214-783-8384

Schedule 1982-83 Projects

June 19 — July 3 — Honduras Summer Project, Rural Honduras
July 31 — Aug. 14 — Haiti Eye Project
Oct. 30 — Nov. 21 — India Encounter
January — Nicaragua Eye Project
February — Honduras Project — Tegucigalpa
February — Dominican Republic — Frontier Project
March — Honduras Project — LaCeiba

Serve medically needy on lush island

Michigan physicians with a strong bent to humanitarian service have a new opportunity to help. The setting is a lush tropical island in the Caribbean, where people until now have had little access to modern health care. A primary and public health project has been underway since June 15 on Roatan Island, the largest of the eight Bay islands 40 miles north of the Honduran coastline. It is supported largely by public and private donors.

Designed by Connecticut-based International Field Studies, Inc., Project Health 2000 offers physicians tax deductible working vacations.

Physician volunteers are needed to provide primary medical attention to island residents. Health professions students also are encouraged to participate in the program. Senior medical students may use this experience as a medical rotation or clerkship with the appropriate clinical support and approval of their academic institutions. Interested physicians may contact Dennis Paradis at MSMS headquarters, 517/337-1351.

Members of Michigan State Medical Society who have been on one or more MGM Missions

Anesthesiologists

John Cowan, MD, Grand Rapids
Marvin Jewell, MD, Detroit
James Shadoan, MD, Chelsea

General Practice

Al Adams, MD, Flint
Allan Alexander, MD, Kalamazoo
Campbell Cutler, MD, Flint
Winslow Fox, MD, Ann Arbor
Clayton Hurd, MD, Fenton
Gerald Moredock, MD, Flint
Harry Nassar, MD, Flint
Brian Nolan, MD, Flint
Ralph Ruckel, MD, Flint

OB and Gyn

Richard McMurray, MD, Flint
Mary Kay Neering, MD, Grand Rapids.
Harry Tarpinian, MD, Detroit

Surgery

Virgil Bonet, MD, Flint
Frank Cook, MD, Flint
Dean Smith, MD, Grand Rapids

Internal Medicine

Don May, MD, Kalamazoo
Ray DeHahn, MD, Kalamazoo
Joan DeHahn, MD, Kalamazoo

Pediatricians

Romulo Alvarado, MD, Flint
William Nichols, MD, Flint
John Reid, MD, Flint

Orthopedics

Hira Branch, MD, Flint

Ophthalmology

Fleming Barbour, MD, Flint
William DeGras, MD, Zeeland
John Dunn, MD, Lansing
David Facunier, MD, Detroit
Paul Geiser, MD, Battle Creek
Steven Kalstein, MD, Flint
Charles McMahon, MD, Ann Arbor
William Schlichtermeier, MD, Detroit
David VerLee, MD, Flint
Arthur Wierenga, MD, Jackson

Physicians for Social Responsibility educate to stop nuclear war

By Martha Climo
East Lansing

"We are but transient passengers on this planet Earth. It does not belong to us. We are not free to doom generations unborn. We are not at liberty to erase humanity's past or dim its future. Social systems do not endure for an eternity. Only life can lay claim to uninterrupted continuity. This continuity is sacred. We physicians who shepherd human life from birth to death, are aware of the resiliency, courage and creativeness that human beings possess. We have an abiding faith in the concept that humanity creates. This perception provides optimistic purpose in reversing the direction of humankind's potential tragic destiny." — Bernard Lown, MD, "Physicians and Nuclear War," *JAMA*, November 20, 1981.

Because of the accelerating build-up of nuclear weapons and the failure to negotiate meaningful arms agreements, physicians and scientists have become increasingly concerned.

An organization called Physicians for Social Responsibility (PSR), a national non-profit organization of MDs, DOs and dentists is reactivating. Founded in 1961, it is dedicated to professional and public education on the medical hazards of nuclear weapons and nuclear war.

Since little information was available on the medical consequences of nuclear war, a group of Boston physicians founded PSR to develop a consciousness among lay people in the United States. The group also was influential in the signing of the Limited Test Ban Treaty in 1963. PSR became dormant, but was reactivated in 1979 when some physicians once again became concerned with the hazards of nuclear power. They ran an ad in the *New England Journal of Medicine* (March, 1979), coincidentally three days before the nuclear power plant accident at Three Mile Island.

Ms. Climo is a Lansing area freelance writer.

Since then, PSR's efforts have blossomed. A national office, library and resource center have been established with full time staff. More than 50 chapters have been formed throughout the country. The number of members has increased by 1,000 percent, and printed and audiovisual educational materials, including a quarterly newsletter have been developed and distributed. PSR now has over 11,000 members with approximately 300 people joining monthly.

PSR in Michigan

A number of years ago, John Caldwell, MD, an internist at Henry Ford Hospital, established the Detroit Chapter of PSR. In 1981, Eugene Perrin, MD, a pathologist at Children's Hospital in Michigan, reactivated the Detroit Chapter. Meetings are held regularly and the membership continues to grow. A speakers' bureau of physicians is available to present the issues to professional and public groups.

According to Doctor Perrin, "As President Reagan has begun to make more and more noise about nuclear weapons, the organization has begun to take off. Similar organizations have started in Canada, Western Europe, Eastern Europe and Russia.

"The basic concern of PSR is to educate the public," he explained. "Our goal is for the United States to sit down on the same side of the table with Russia and to police other unstable countries which have nuclear weapons. There won't be any doctors, police or firemen to help out in the event of such a catastrophe."

According to Daniel English, MD, professor of surgery at Michigan State University and adviser to a student PSR group in East Lansing, the name of the organizationi is misleading and the responsibility of the group is very narrow.

"We have not even gotten into areas such as preventive medicine, the distribution of health care technology and systems, and the assessment of health care needs.

He said physicians involved in PSR are trying to provide education and information to the public and to policy makers.

"Some people are concerned that we are getting outside our regular responsibility, but that's presumptuous. By virtue of our area of expertise, we can say that our medical resources cannot cope with a nuclear war. So it must be prevented." Doctor English explained.

"The idea of a nuclear war is so desperate and terrible. You can't kid yourself that we can return to business as normal two weeks after a nuclear war. We must get the attention of those policy makers in power."

PSR beliefs

PSR members believe that (1) nuclear war would result in death, injury and disease on a scale unprecedented in the history of humanity; (2) medical disaster planning for nuclear war is meaningless; (3) no effective civil defense exists; (4) recovery from nuclear war would be impossible; (5) no one can win a nuclear war.

In PSR's efforts to educate the public, it appeals to people to defuse the current tensions between our countries, to ban the use of all nuclear weapons, to recognize the threat posed by the very existence of our enormous nuclear arsenals and to begin to dismantle them.

More on page 372

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Seot. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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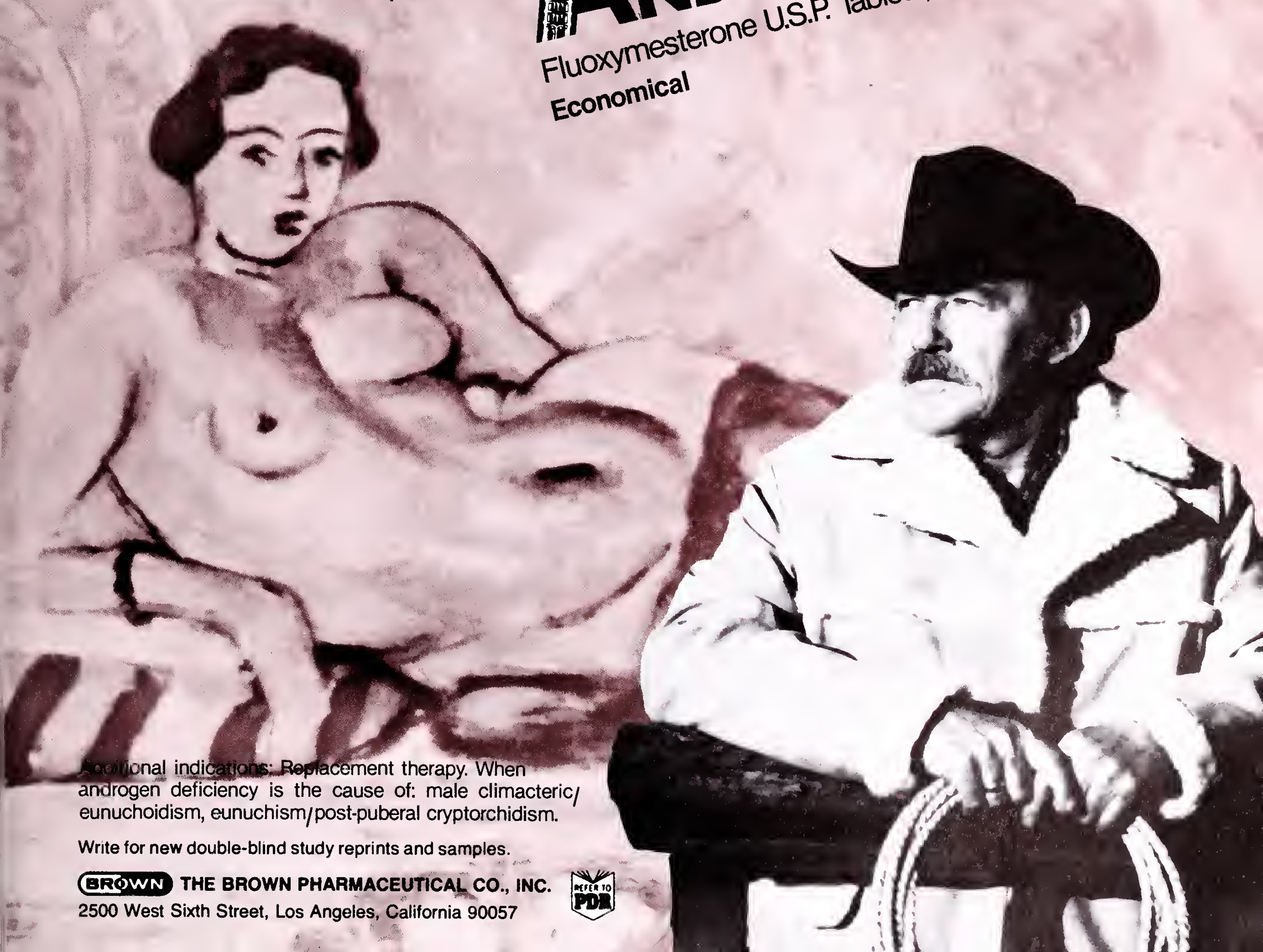

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.

Write for new double-blind study reprints and samples.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Tips from the Pros.

The Slant on Sidehill Shots

When you're facing uphill, with the ball resting above your feet, you should stand a bit farther from it than normal. You should also make a "flatter" swing than normal, more like a merry-go-round than a ferris wheel.

When facing downhill, with the ball below your feet, stand closer to it and swing more "upright", like a ferris wheel instead of a merry-go-round.

In either instance, it's always best to take a couple of practice swings. It's also wise to swing with less effort than normal in order to retain your balance.

The Topspin Forehand Swing

There is no wrong time to hit a topspin. If you can hit it regularly—use it. All the pros do.

The key to the topspin forehand is your ability to get under the ball and swing up quickly. The forward swing of the flat foreward drive begins as if you were sweeping off a table top with your arm. Only after you have made contact do you begin to raise your racket and finish high. And as you finish, you swing out to the court.

For the topspin forehand, the rapid upward movement from below the ball makes all the difference.

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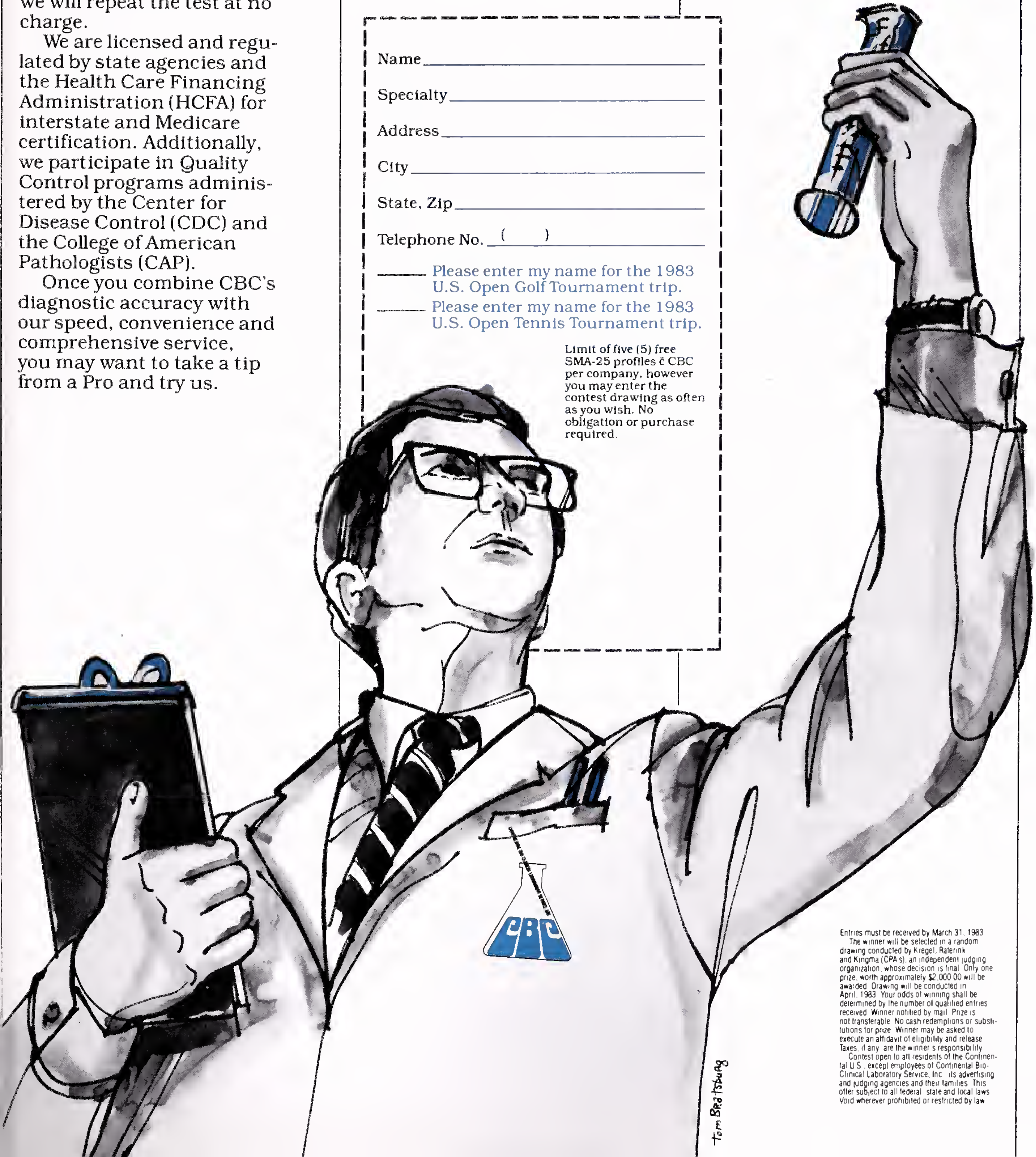


Entries must be received by March 31, 1983.

The winner will be selected in a random drawing conducted by Kregel, Raterink and Kingma (CPA's), an independent judging organization, whose decision is final. Only one prize, worth approximately $2,000.00 will be awarded. Drawing will be conducted in April, 1983. Your odds of winning shall be determined by the number of qualified entries received. Winner notified by mail. Prize is not transferable. No cash redemptions or substitutions for prize. Winner may be asked to execute an affidavit of eligibility and release. Taxes, if any, are the winner's responsibility.

Contest open to all residents of the Continental U.S., except employees of Continental Bio-Clinical Laboratory Service, Inc., its advertising and judging agencies and their families. This offer subject to all federal, state and local laws. Void wherever prohibited or restricted by law.

Do physicians have a responsibility?

From left, Howard Brody, MD, PhD, acting director, MSU Medical Humanities Program; Dan English, MD; Martin Benjamin, PhD, and L. Rao Kareti, MD. (Photo by Bill Mitcham, MSU)

Faced with the potential threat of nuclear war, do physicians have a responsibility?

On May 17, the Michigan State University Medical Humanities Program and Lansing-area hospitals sponsored a panel discussion on the subject.

The options for physicians taking a social responsibility range from a strong responsibility to no responsibility, said Martin Benjamin, PhD, MSU Professor of Philosophy.

"Physicians taking a strong responsibility would not only inform the public, but refuse to comply with any plan or government request that increases the possibility of nuclear war," Doctor Benjamin said.

"Physicians taking a moderate position must direct their special medical knowledge to make clear to the public what the consequences would be," he explained.

He said that some physicians believe that as citizens they have a responsibility to contribute to the debate over nuclear war, but that as physicians they do not, because they have no expertise in the complex social issues.

"The argument for those physicians who believe in taking no responsibility is that in accordance with the Hippocratic tradition, their chief responsibility is to their patients," Benjamin said. "Furthermore, with the limitations of the 24-hour day, whatever time is left over is for the family and relaxation. Recognizing a division of labor, they know that some physicians are already hired by the government to work in this area.

"However, the argument against this position is that it is too narrow," Doctor Benjamin said. "A physician would have to be concerned with patients after a nuclear exchange, so it is best to try to prevent one. Furthermore, it's not possible to rely on government physicians because they are not entirely free. They lack critical independent judgment."

The second speaker on the program, Daniel English, MD, MSU Professor of Surgery, said, "The results of a nuclear exchange are death and injury. People cannot be treated or fixed or repaired. Policy regarding nuclear armament should not be made ignoring these consequences."

He said the public should have greater participation in prevention.

"Physicians need to play a huge educational role. They have power. They control the systems and that implies responsibility."

English explained that physicians have a huge indebtedness to society.

"They are handsomely rewarded for their services. They have an indebtedness to medical education, to schools, hospitals and laboratories which all are paid for and to patients for experiments and interactions. We must be doctors and more," he said.

L. Rao Kareti, MD, Chief of General Surgery, St. Lawrence Hospital, Lansing, raised the question whether the discussion should focus only on one society or on people all over the world. He said that the ultimate responsibility does not come from just a group of physicians, but from the voice of the human being.

"It is foolish to assume that everyone will drop dead," Doctor Kareti said.

"It is irrelevant to try to bring about responsibility of scientists, for ultimately, it is man himself and not any one group."

During the question and answer period, Doctor English emphasized his point that, "Physicians have an obligation to say 'you can't fix it.' Physicians must work on ways to prevent a nuclear holocaust, but not to set policy.

Physicians who wish to join Physicians for Social Responsibility should write to PSR, 639 Massachusetts Ave., Cambridge, MA 02139. By joining the national group, physicians automatically are members of their local chapters.

The following is a list of contact people in various parts of Michigan:

Mark Leventer, MD
761 Student Center Building
Wayne State University — Newman Center
Detroit 48202
Tel. 1-313-577-3168

Donald L. Rucknagel, MD
1141 Clair Circle
Ann Arbor, 48103
Tel. 1-313-763-2533

Robert Soderstrom, MD
11414 Woodbridge
Grand Blanc 48431

Peter Barker, MD
722 North Sycamore
Lansing, 48906
Tel. 1-517-372-1438

John F. Reuwer, MD
537 Lafayette S.E.
Grand Rapids 49503
Tel. 1-616-774-6789

Richard W. Hodgman, MD
3828 Old Colony
Kalamazoo 49008

John M. Caldwell, II, MD
1903 Oakland Drive
Mt. Pleasant, 48858

Michael Koyne, MD
1414 West Fair Ave.
Marquette 49855

More on page 376

1980's period of economic ferment; planning for retirement requires much time

John Greenleaf Whittier was referring to a lost love when he wrote, "Of all sad words of tongue or pen / the saddest are these: 'It might have been.'" So too, however, might run the lamentations of many physicians who have failed to plan wisely for their retirement.

Part of the problem for many physicians is the "kid in a candy store" syndrome when confronted by the myriad attractive options for investment: stocks, money purchase plans, real estate, annuities, municipal bonds, tax-sheltered investments. Knowing the right investments to make for a secure retirement is a critical decision that requires calculated and prudent planning.

What are the steps in developing a "prudent" plan? Common sense dictates that for a plan to be successful it must have achievable goals. So the first step in developing a retirement plan is to define your goals. At what age do you wish to retire? What monthly payment from your plan will you need? How much are you willing to invest each year?

If you are uncertain of the answers to these questions, you may need an investment counselor. Talk to friends and to acquaintances who are retired. They can usually suggest the names of counselors who have a track record of success. Resist the temptations to use your business manager, either as an investment counselor or as a source of information. The potential for conflict of interest is exceedingly high and this is a long-range decision that requires your personal involvement — and understanding. Read one of the many books available on this subject. Prepare a worksheet that will tell you the following information:

- The amount that is currently in your retirement fund and its projected growth.
- The amount you intend to contribute annually to your retirement plan and the estimated return from this investment.

From the sum of these two figures you will be able to project the size of your monthly pension over the period of your life expectancy. When speculating the rate of return for your investments, be conservative; eight to 10 percent is probably a reasonable figure.

Your next step is to evaluate how best to invest your retirement plan contributions so they will produce the income you will need at retirement. Too much hassle, you say? In an article in the March 2, 1982 *Medical Economics* several retired physicians commented on the changes they would make if they had their careers to live over. Most of them said they would spend much more of their time evaluating their investments and retirement plans.

Certainly, the key to sound planning for your retirement is discipline and a willingness to surrender some of today's pleasures for tomorrow's security.

Another step in your planning is to manage your practice in such a way that income is maximized during your peak earning years. Close attention to your accounts receivable and following up with third-party payers may seem mundane details, but there are large sums that annually are lost by physicians who ignore such details.

The choice of a properly blended investment mix for your

This article is excerpted from a larger section on practice management being prepared by the MSMS members' manual, "Meeting the Challenge of the 80s." the manual is the project of the MSMS Committee on Public Service, chaired by Robert D. Burton, MD, Grand Rapids. Excerpts will appear in Michigan Medicine *throughout 1982. They are designed to be removed easily and saved for reference.*

retirement plan is a matter that is too involved and too personal for treatment here. However, there is a seductive phrase that seems to be causing much grief for some physicians. This phrase is "tax shelter." It is astounding how many investors overlook the "fine print" in tax shelter schemes that point out the risk factor and the fact that taxes are usually deferred rather than reduced.

Tax shelters are, in many ways, like the tar baby that snared Br'er Rabbit — hard to get out of once your're in. The first question you should ask is "What is it going to cost me at the end of the shelter period?" Is the return worth the worry that goes with entering a high-risk venture?

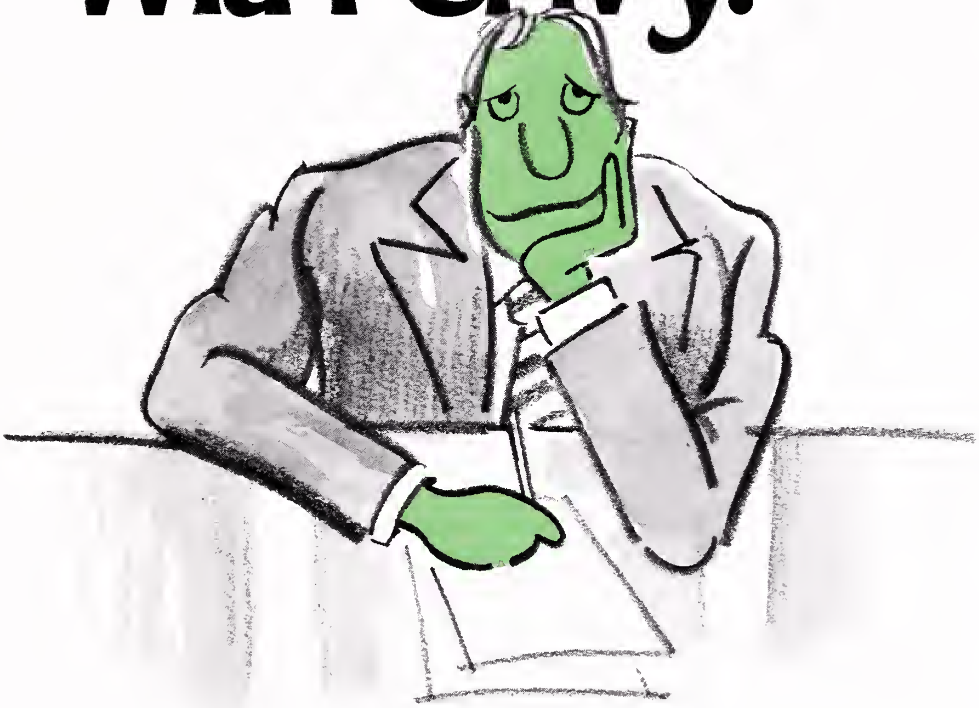
Some other questions you should ask about a tax-shelter proposal are:

- Do I know enough about the venture to recognize its potential for success?
- Do I want future income or an immediate tax break from this investment?
- Has the promoter shown me enough background detail so I fully understand the risks (READ THE PROSPECTUS)?
- How much up-front profit (management fees) is the promoter making — regardless of the success or failure of the venture?
- Who else is participating and what is their reputation?

Remember, return on investment is almost always correlated to the amount of risk. That's the purpose of tax-sheltering. It is government's way of encouraging risk-venture capital investment.

There are many other investment opportunities that can and should be important elements in your retirement plans. The '80s will be a period of economic ferment as inflation, labor unrest, social and industrial reorganization, competition in the medical marketplace, and numerous other factors come into play. Planning for your retirement years is a great challenge — one requiring a sizable investment of your time.

NBD's Investment Services turn brokers green with envy.



If you are an investor with sizable funds and securities, you'll probably find you're a lot better off using NBD's Investment Services than you would be with a stock broker. First, NBD's charges are based on the size and growth of your account rather than the number of transactions. That means the better you do, the better we do.

But a key difference between NBD and a stock broker is that we treat your investments as an integral part of your overall financial situation rather than isolated transactions.

This means one of our planning officers will start by reviewing your assets with you, and evaluating current and future income requirements. This is the first step in clearly identifying your investment needs. Every aspect of your current holdings will be included: bank accounts, life insurance, real estate, personal property, existing securities—even pension plans and profit sharing. Next, the planning officer will help you develop an investment plan based on your needs and goals. Finally, with the help of NBD's investment specialists, we will put the plan into action. You may be involved to the degree you wish, and we will review all investments with you on a regular basis. This comprehensive planning approach assures you of maintaining a sound, well-managed portfolio that reflects your overall financial objectives.

If you're an investor with a portfolio of over $100,000—and you'd like to find out more about our investment services contact the NBD planning officer at any one of the area offices below:

NBD NATIONAL BANK OF DETROIT

Bloomfield Hills
Ed Forton or
Henry Woloson
(313) 645-6600

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Stu Kerr
(313) 593-1131

Detroit
Parker Colby
(313) 225-2912 or
Bud Hudson
(313) 225-1688

Grand Rapids
Ron Ostan
(616) 538-7490

Grosse Pointe
Bob Hackathorn
(313) 886-4014

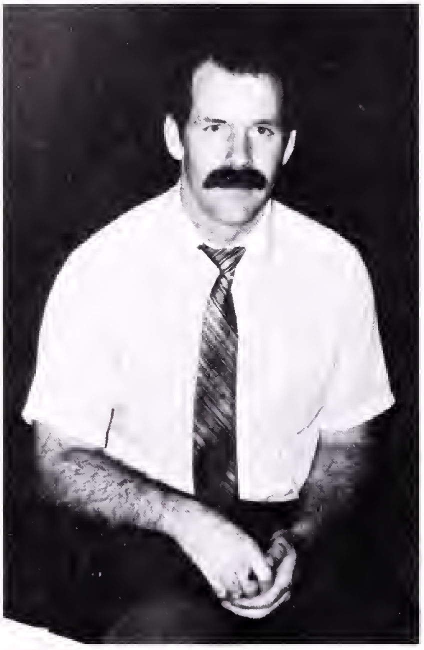
Lansing
Tom Swets
(517) 371-1333

Saginaw
Dick Stringer
(517) 771-2525

Traverse City
Dave Williams
(616) 941-4440

You've come a long way, Doc!

By Willah Weddon Stockbridge



Doctor Frank

"The first time I heard about DOC (Doctors Ought to Care)," Scott Frank, MD, says candidly, "I resented it a little bit."

"To me, DOC implied that doctors didn't care and that's not true. It's often thought by the public that it is true, but doctors do care and care very much.

"Doctors have never really had a way of expressing how they care, in an organized fashion," he qualified, "And I think that's what DOC is all about."

Doctor Frank, a resident physician in family practice at the University of Michigan Medical School, became president of the state chapter, DOC'OM (Doctors Ought to Care of Michigan) in 1981 and is a member of the national DOC board of directors.

Health risks

The national objective is to provide information to the public about health risks. This involves alcohol, nutrition, drug abuse, teenage pregnancy, and cigarette smoking.

DOC'OM was formed as a part of a research project in community education in the University of Michigan's Family Practice Department, to investigate whether counter-advertising and social support may limit the urge among teenagers to start smoking.

"Since smoking is the nation's number one cause of preventable poor health, it has drawn our number one priority," Doctor Frank explained. "But smoking is merely a symbol of the kind of health risks peddled by the ill-health hucksters."

He's convinced the unique approach to health risks employed by DOC will be successful in the long run, but at this time medicine is losing the battle with Madison Avenue.

"Patients continue to be enticed by the manipulations of Madison Avenue into health-stealing behaviors such as smoking, excess alcohol consumption and poor nutritional habits," he asserts.

"For each time a health professional informs a patient of the four major food groups, "Twinkie the Kid" gallops across the TV screen 10 times, extolling the nutritional value of Twinkies.

"For every time a physician reminds patients of the importance of seatbelts, the "Dukes of Hazzard" smash another 20 cars, then walk away unharmed.

"For each time we tell a patient that alcoholism is a fatal disease, there are 30 washed-up jocks informing us that since their beer is lighter, you can drink more and more and more.

"And, for every time we tell a patient that smoking will rot his lungs, there are 100 models with lungs you wouldn't believe telling him differently.

Seductive voice

"Medicine is being deliberately undermined and decidedly outmanned by a Madison Avenue voice so loud that it renders ours inaudible, and so seductive that it renders our impotent."

As Doctor Frank sees it, the area of health education is traditionally very difficult for physicians. "Prevention is difficult to measure; and as medical students, we're taught if something can't be measured, it isn't worth doing." Also, it's frustrating because it often is difficult to talk to someone who smokes about stopping smoking or to a person who's an alcoholic, to stop drinking, he said.

"We often find ourselves so uncomfortable that we stop doing it," he pointed out. "We feel a bit like spoil-sports, telling people they can't smoke, they can't drink.

"DOC takes the party-pooper ideas and presents them in a life-of-the-party fashion," he continued. "DOC tries to talk to people in a different way . . . the way people understand."

This is how the 26-year-old, enthusiastic graduate of the University of Michigan Medical School comes across as he speaks to students, union groups and community organizations. He talks to teenagers, target groups in junior high and high school, using the same techniques employed by television commercials and other media advertisements.

Humor, satire

He uses irreverence, humor, satire and the teenage vernacular. An illustration of this is the national poster DOC supplies, satirizing the classic cigarette ad, "I smoke for taste." In DOC's version, the macho model has a cigarette dangling provocatively from his nostril as he says, "I smoke for smell."

Despite all the advances made in medical treatment, Doctor Frank believes the health of the country's population will deteriorate if the truth isn't sold, as well as told. "This can only be done with exposure and that depends on the generosity of the public in terms of tax deductible donations," he pointed out.

He was referring to a counter-advertising campaign DOC hopes to mount through television, newspapers and radio. Plans also call for the production of a slide presentation and script which can be supplied to doctors throughout Michigan for use

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Ms. Weddon is a Lansing area freelance writer.

in a grass roots campaign to reeducate the public.

Other people, as well as doctors, 'ought to care,' Doctor Frank asserted.

And many of them do. Members in DOC'OM include physicians, residents, medical students, nurses and health educators as well as lay people who are willing to donate their services or funding.

Although Doctor Frank will complete his residency this summer and move, with his wife and their infant son, to Cleveland, where he will be a Robert Wood Johnson Fellow in Family Medicine at Case Western Reserve University, the program will continue. A unit of DOC'OM has recently been established in Flint. Kalamazoo and Grand Rapids family practice residencies also are considering forming units.

Anyone interested in becoming a member or sponsoring a program in their community may obtain details and make arrangements for speakers by writing to Scott Frank, MD, or Mike Klinkman, MD, c/o DOC'OM, 775 S. Main, Chelsea, 48118.

Marlboro Country.

One of several DOC stop-smoking advertisements.

In 1977, when the Veterans Administration compared Step-2 regimens in 450 mild hypertensive patients,

which regimen was proven most effective?[1]

Michigan's Genetic Services Program one of three in the country

By Susan Letwin
Trenton

Genetic disease and birth defects claim the lives of 60,000 Americans a year.

Five to 10 percent of the population will be afflicted with a birth defect or genetic disease at some point in their lives, and countless family members will need professional counseling to help them cope with problems such as how to give their affected relatives the best care and support possible.

To combat this problem in our state, the Michigan Department of Public Health has established a unique Genetic Services Program. It provides referring physicians and their patients with diagnostic services, information, and counseling.

Michigan is one of only three states in the country with such a program.

The program consists of five genetic centers which are associated with 12 satellite clinics. Although genetics services require a group of specialists such as those found in the centers, the satellite clinics are a key element of the program. William Young, MD, program director with the MDPH explained that people are more likely to use the service if it's available in their area. Patients are counseled at satellites, some testing is performed, and samples needed for more sophisticated analysis are obtained to be sent on to the satellite's associated center. This arrangement insures a uniform statewide standard of care and promotes genetic research. Data gathered at each center is obtained using a standardized form that can be fed into a computer for later study by any interested network member.

Cooperation is a main feature of Michigan Genetic Services, both within the center network and with other health care professionals in the state. Diane Baker, MS, genetic counselor at the University of Michigan's Medical Center, Section of Pediatric Genetics, explained that there is a close relationship between the geneticist, the primary care physician and the family.

The genetics centers have the expertise, facilities, and time to work with genetics or birth defects problems, but it is the primary care physician who knows the family best. The family doctor helps the patient and the center by acting as an intermediary between them. The center can provide the doctor with information, then he or she can decide how to present it to the family.

Physicians can use the Genetics Services Program by calling the closest center or satellite clinic for a referral. The State Department of Public Health has just mailed out a pamphlet, "Michigan Genetic Services Program" to all physicians in the state. Interested doctors can find center phone numbers and specific locations in it. The booklet also details the specific services offered. These include genetic counseling, diagnosis and syndrome identification, referral for treatment and follow-up, and prenatal diagnosis.

Jacquelyn Roberson, MD, who is the director of the Perinatal Diagnostic Program at Henry Ford Hospital's Medical Genetics and Birth Defects Center, explained more about what goes on in a genetics clinic.

The geneticist's most important task is establishing a correct diagnosis. This may sound obvious, but the center sees many people who were misdiagnosed years ago. When they are retested with today's more sophisticated techniques the geneticist discovers that the patient has a condition different than the one he or she came in for.

Providing information is one of the center's main goals. Doctor Roberson said that a large part of the population doesn't realize what services are available to them. To help reach them, the center gives classes for professionals such as public health nurses who can help teach others. The center's patients require information about what is happening to them and what they can expect in

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Ms. Letwin is a Detroit area freelance writer.

Birth defects affect one of every 12

What kind of a toll do birth defects take on Americans each year?

According to Genetics Program Coordinator, William Young, PhD, Michigan Department of Public Health:

- **Birth defects and genetic disease affect one of every 12 infants born each year.**
- **Birth defects and genetic disease cause more than 60,000 deaths annually in the US.**
- **One in 200 infants is born with a chromosome abnormality.**
- **One in 100 newborns has a defect due to major mutant genes.**
- **Birth defects constitute the third most common cause of death to age 14.**
- **It has been estimated that more than 20 percent of pediatric hospital admissions are for conditions wholly or partly genetic in origin.**

the future so they can choose between the many options available to them. No matter which option a patient decides upon, the center provides support and follow-up care.

For example, Doctor Roberson had a follow-up appointment with a couple whose child has sickle cell anemia. The parents are both carriers so they came to the center for amniocentesis. They discovered that the fetus was positive for sickle cell. But they decided to have the baby and care for it themselves rather than terminate the pregnancy, place the infant in foster care, or put it up for adoption. Doctor Roberson will continue to help the parents give their baby the special care it needs. They need to know things such as how important it is to take the baby to the family doctor when it is ill. They need to know that what may be a minor illness in a normal baby may be a crisis for a sickle cell infant. The center will send letters to the primary care physician to keep him informed about the counseling sessions.

Ms. Baker elaborated further about the four basic groups of people that center staff counsel. The first group consists of young couples who come in because their newborn has a serious defect or isn't thriving. Ms. Baker tries to find out how well the parents understand and accept what is happening to their baby, then she tries to get the couple talking to each other and to the people around them. Since this is often the first crisis that a young couple faces together it can cause marital problems. Other problems arise when friends or relatives question decisions the couple reaches. In this case, center counselors support the parents and explain to others, if necessary, why the parents reached the decision they did.

The second group, parents whose children have a disease or defect caused by teratogenic agents, have the same problems.

Counselors help many couples who need information before they start a family. They may be concerned because one spouse had a retarded sibling or was exposed to a potentially harmful drug.

Center counselors also see people with adult onset diseases such as Huntington's. These people need help because their condition affects not only them but also their children. Counseling helps them through the crisis of learning about their disease and can help with questions such as how much information should be shared with their families.

All the patients who use the Michigan Genetics Services Program are put in touch with other resources available to them and receive counseling and support from the program as long as they desire it.

Program Director Young reports that all the centers and satellites are thriving, but that they could be used more. At the current level of funding the program could see about 1,000 families; but they will only see 600.

Physicians who did not receive a copy of the brochure "Michigan Genetics Services Program" or would like more information may call Doctor Young at (517) 373-0667 or write to:

William Young, PhD
Director of the Michigan Genetic
Services Program
Michigan Dept. of Public Health
3500 N. Logan St., PO Box 30035
Lansing, 48909

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), **which Step-2 regimen was preferred and was deemed effective without significant adverse effects?**[2]

1982 MSMS Annual Scientific Meeting follows participants' suggestions

You asked for it — you got it!

We are referring to the courses planned for the 1982 MSMS Annual Scientific Meeting Nov. 9-10-11 in Dearborn. Many of them are part of the program specifically because MSMS members who attended the 1981 event asked for them.

Annual Scientific Meeting Task Force Chairman Frank Cox, MD, Detroit, and his committee members carefully analyzed the results of the evaluation form returned by 1981 course participants to ensure as many as possible of those physicians' requests were honored as they planned this year's big three-day meeting.

Site of the Annual Scientific Meeting again is the Hyatt Regency Dearborn, were facilities are ideally suited to the MSMS event. The large exhibit hall, MSMS meeting registration desk and most classrooms are in close proximity with each other in a new wing of the hotel.

New Courses

Among the new courses this year which have been arranged at MSMS members' request are:

"Emergency Psychiatry for the General Physician"
"Stroke 1982: An Update in Current Diagnosis and Treatment"
"Anti-Substitution: Dangerous Drug Decisions"
"Medical Genetics for the Practicing Physician"
"Depression: Modern Concepts in Recognition and Treatment"

Courses which are being repeated at last year's participants' request are:

"Clinical Determination of Mental Capacity"
"Causes and Prevention of Automobile Crash-Related Injuries"
"Aging — Is It Worth It?"
"Basic Cardiac Life Support"
"Dermatology for the Non-Dermatologist"
"Diabetes — Current Concepts and Update"
"Acute and Chronic Back Pain"

This year, 55 half-day Category I courses are planned for the Annual Scientific Meeting, and physicians again may earn a total of 18 credit hours. Courses run from 8:30 AM to noon and from 1:30 PM to 5, with half-hour coffee breaks.

Each course awards three Category I credit hours and is presented by a specialty society, MSMS section, or a department of one of the state's three medical schools. Courses undergo a rigorous accreditation process and must be approved by the MSMS Annual Scientific Meeting Task Force in order to award Category I credits.

The task force attempts to provide a broad range of topics particularly useful for the practicing physician in the various primary care areas, according to Doctor Cox. The Task Force also provides courses targeted at specialty groups.

In this day of cost-consciousness, the task force strives to make this the best buy for physicians' money, and the best quality program in the country, to make it worth the physician's time away from home and practice. The Annual Scientific Meeting annually draws raves from the seasoned speakers and course directors who participate in medical meetings from coast to coast.

Doctor Cox, who is director of the Office of Continuing Medical Education at Henry Ford Hospital, gathers a renowed and highly expert faculty from Michigan and other states. The speakers widely represent the medical schools and major medical institutions of the state.

The Hotel

The Hyatt Regency Dearborn offers most congenial facilities for the meeting, with its 12-story atrium, wide variety of restaurants, "people-mover" automatic bus connections with the Fairlane Shopping Center, and proximity to Greenfield Village and Henry Ford Museum.

MSMS again will arrange luncheons for course participants and late afternoon refreshments.

The exhibit hall, featuring booths by MSMS, affiliated organizations and 75 commercial exhibitors, will be open each day and will serve as the setting for the MSMS-arranged luncheons and refreshments.

A full list of courses appeared in the June 24 issue of the MSMS *Medigram* newsletter. Registration forms and complete course information will follow in the September *Michigan Medicine* and September and October *Medigrams*.

NEWS

By Sheri W. Greenhoe
East Lansing

Doctor Igna

Doctor Slee

New chairman of the Board of regents of the American College of Physicians is **Beverly C. Payne, MD,** clinical associate professor, University of Michigan Medical school. Doctor Payne was elected at the national specialty society's four-day annual scientific meeting in Philadelphia recently. New chairman of the ACP Board of Governers is **Boy Frame, MD,** clinical professor of medicine, U-M Medical School, also elected at the Philadelphia meeting. . . . **Eli J. Igna, MD,** Grosse Pointe gynecologist, was recently awarded the Outstanding District Service Award by the American College of Obstetricians and Gynecologists. The award recognizes Doctor Igna's achievements and contributions to his field . . . New president of the Wayne State University School of Medicine Alumni Association is **Hershel Sandberg, MD,** chief of endocrinology at Sinai Hospital in Detroit. Doctor Sandberg was installed at the organization's Medical Alumni Reunion Day in May. . . . Ten long-term Providence Hospital physicians were honored at an appreciation dinner sponsored by the Providence Hospital Foundation recently. Recognized for years of dedicated service were **Gerald J. Aben, MD,** Wyandotte; **Gerald Adamian, MD,** Southfield; **Donald I. Bryan, MD,** Dearborn; **Richard Donovan, MD,** Detroit; **Arch Kane, MD,** Birmingham; **Vincent J. Marecki, MD,** Dearborn; **Eugene Otlewski, MD,** Southfield; **James Pingel, MD,** Birmingham, and **Oscar Schwartz, MD,** Huntington Woods. . . . **Robert F. Wilson, MD,** chief of thoracic and cardiovascular surgery at Harper-Grace Hospitals, was co-chair of an international cerebral resuscitation symposium in Detroit recently. . . . President Emeritus of the Commission on Professional and Hospital Activities, **Vergil N. Slee, MD,** Ann Arbor, was presented the Richard and Hinda Rosenthal Foundation Award by the American College of Physicians during a recent convocation program in Philadelphia. . . . The "Book of Golden Deeds" was presented to **Olin Lepard, MD,** Sturgis, by that community's Exchange Club recently. The top award for excellence in professional work and community service was presented to Doctor Lepard by community leaders who expounded on his service to the local school board, athletic program, Kiwanis Club and church . . . MSU professor of OB/GYN, **Gerald B. Holzman, MD,** has been named by the National Board of Medical Examiners to its Obstetrics-Gynecology Test (Part II) Committee. . . . "Let's

Continued on page 390

Ms. Greenhoe is Editorial Secretary to *Michigan Medicine.*

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, **which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?[3]**

MSMS presented a unique conference May 6 in Southfield, tailored to the needs expressed by the participants themselves, who were Michigan women physicians. The physicians sat at round tables, where they mapped strategies on large sheets of newsprint for becoming a force in medical politics, and learned to cope with the multiple demands on their lives. Over 80 women MDs took part in the conference.

MSMS gathers women physicians for conference

Among the participants were two politically active women physicians in Michigan, Vivian Lewis, MD, Flint, left, past president, Genesee County Medical Society, and Susan Adelman, MD, Detroit, president-elect, Wayne County Medical Society.

Key persons in the conference were Linda J. Logsdon, MD, Southfield, left, chairperson, and Ronald Lippitt, PhD, Ann Arbor, facilitator.

What is a good patient?

By Charles E. Payne, MD
St. Joseph

The following article is excerpted from one which first appeared in the March, 1982 "Riverwood Report," newsletter of the Riverwood Community Mental Health Center in Berrien County. It has application to all physicians who see patients.

The motivated patient makes us feel good, indicating we are accepted and needed. The paying patient makes it unnecessary to worry about that uncomfortable subject — money. The person with few serious symptoms makes diagnosis easy and the prognosis good. This, too, makes us feel better.

The rapid response to our ministrations, especially as we expound our favorite therapeutic philosophy, confirms our beliefs with positive feedback, assuring us of our own hard-won philosophical rectitude. The intelligent, articulate, cooperative patient makes few demands, stimulates our own minds, and never calls after hours or raises difficult questions.

But what about the others? What about the poorly motivated, impecunious clod who comes late, doesn't remember a thing you said and generally smells bad and plays "yes but" games?

What about the person who is negativistic, withdrawn, and stubborn about implementing our ideas for action? What about the patient who brings up all those primary process ideas so scary in ourselves and which we would prefer to leave undisturbed in the backward reaches of our minds?

What about the dependent, demanding, "mary" martyrs who have a grocery list of somatic complaints and an impossible situation at home for which there either is no answer or

Doctor Payne is the senior psychiatrist at Riverwood Center, and is board-certified.

Are the results of
$100 million worth of
government-funded research
on hypertension
worth reading about?

only options she won't accept? What about the big bruiser with the hostile scowl, coming under protest, conveying the feeling that death and destruction are not very far underneath? What about the suicide threat that sounds real, the unwashed, the unlovely? How could any of these be "good?"

Well, good for what? No, they are not good for our immediate reassurance of our professional expertise. They are not an intellectual challenge with sophisticated oedipal dynamics. They are not good for our insecurities, our unresolved complexes, or our desire for rest from effort. They are surely not good for our pet ideas of the royal road to psychological bliss.

If we believe that the worst of us is still of infinite worth, if we believe we are alike in more ways than we are different, if we believe we owe something to the less fortunate than ourselves, if we have our own act together and give up our childhood fantasies of ease and satiation, if we believe the cynical bitterness of the character disorder covers an inner heart filled with despair from past rejection and abuse, if we believe the psychotic in panic over his inner terrors deserves surcease, if we believe the schizophrenic deserves one human contact with acceptance free of ambivalence and double binding, if we believe members of a minority race deserve to be treated with decency and respect due our own kind; if we believe all this, then what is a good patient?

Believe it or not, doctor,
it's the combination found in...

Salutensin®
(hydroflumethiazide 50 mg/
reserpine 0.125 mg)

And don't the results of more than
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who were followed for several years,
merit your serious consideration?

The ultimate service to mankind

By Richard W. Hodgman, MD
Kalamazoo

It has been 37 years since mankind discovered how to unleash the enormous energies in all matter, and exploded the first nuclear device. Appropriately, the awe of this achievement was tempered by the even more awesome responsibilities this development laid on the people of the world. Farsighted people saw the possibilities of these forces and warned of the dangers. Einstein said, "The unleased power of the atom has changed everything, save our way of thinking . . . "

As I see it, our way of thinking still hasn't changed very much. We still cling to the notion that security in our world of soverign states is found in military power, and that threats to a nation's vital interests must be met by the threat of war. In this setting we and the Soviet Union have been locked in a nuclear arms race that is now escalating rapidly. Yet our technology, and the industry that feeds it, is now making events we once thought unthinkable increasingly possible. The nuclear weapons that we have depended on for three decades for security are now leading to our insecurity, and as the megatonnage of killing power in our arsenals multiplies we are drifting into an unknown of possibilities that numbs our thinking.

In this frightening situation it is time that we overcome the denial process that has prevented us from coping with this reality and start thinking very clearly about where we are heading. To speak out about the risk of nuclear war, which threatens the very survival of our species, is not irrational. To not think about it, and to not try to do something about it seems so irrational it could be called insanity!

Doctor Hodgman is a surgeon and is chairman of the Kalamazoo Academy of Medicine's Ad-Hoc Committee on the Medical Conferences of Nuclear War.

And there's more proof on the way!

1982 will see the completion of the Multiple Risk Factor Intervention Trial (MRFIT)—a six-year, 12,000-patient study assessing the factors that increase risk of cardiovascular disease. For the management of hypertension, the preferred Step-2 regimen in this study is reserpine-thiazide.

In 1978, in a preliminary report presented to the Epidemiology Section of the American Heart Association (Dallas, Nov 1978), after 12 months of the trial, fewer patients (5.3%) treated with reserpine suffered depression than even the untreated control group (7.7%)!

Please see references and brief summary of prescribing information on last pages of this advertisement.

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Division of Bristol-Myers Company
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Signature __________

SM-2348 11/81

As doctors we are in a unique position to help our world out of this dilemma. Unlike some who would say that doctors ought to stick to what they do best and take care of their patients, I would say we have a moral obligation, as guardians of the public health, to become informed on the medical consequences of nuclear war, and to educate our citizens and our government.

We are respected as humanitarians, and also for our training and knowledge. People will listen to us!

And I would further submit that we are the real experts on these matters. We know what can and cannot be done in settings of mass casualties; we alone really understand the epidemiologic results of the pervasive and cumulative effects of ionizing radiation on living cells; we can understand the catastrophic biologic effects of unfiltered solar ultra-violet radiation that is known to occur when nuclear explosions deplete the earth's ozone layer. And perhaps we can comprehend better than anyone else the horrifying prospects of human extinction in a nuclear holocaust.

The medical profession can gain in stature and credibility and perform perhaps the ultimate service to mankind if we physicians can be instrumental in helping people gain the awareness needed to find a solution to this most pressing issue of our time.

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Brief Summary of Prescribing Information (12) 10/27/78
For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

New Medicaid Primary Sponsor Plan provides forum for cooperation

By Cecil R. Jonas, MD
Detroit

Some months ago the Medicaid primary Sponsor Plan was born of the union of an MSMS/MAOPS task force formed to carry out a legislative mandate to help the state hold down Medicaid costs.

Certain facts were self evident.

1) The State no longer could afford the Medicaid benefit package promised recipients — the amount now stands at 14 percent of the budget.

Physicians' reimbursement dropped to 55 percent of Medicare with no rise in sight. Physicians were disenrolling en masse, others with large Medicaid practices faced financial ruin. They could not understand why they were consistently identified by both the legislature and the Department of Social Services as the major culprit of the cost increase, when they repeatedly were being asked to make the greatest financial sacrifice.

2) The physician's pre-eminent position in the health care system effectively places him or her in control of 75 percent of the health care costs even though the physician's direct revenue from these expenditures is about 19 percent (HHS figures).

3) There were a few documented and some implied cases of both physician and patient abuse that needed to be controlled. Department of Social Services' data shows approximately one percent of participating physicians incurring 20 percent of the costs.

4) Most importantly, for reasons not apparent to apolitical physicians, the Medicaid reimbursement formula (even in the now prospective basis) shows a very strong bias towards institutional, particularly in-hospital care — nearly 40 percent of total Medicaid costs.

Doctor Jonas is a Detroit obstetrition/gynecologist and a member of the MSMS Medicaid Liaison Committee. He is serving on the Medicaid Primary Sponsor Plan Steering Committee.

ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

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References:

1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

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VIEWS/*Continued*

We all are aware, or should be, that a patient seen in a hospital clinic costs the state upwards of five times as much as when seen in my office or yours. We are told there are "overhead fixed costs and facilities' fees," which by some bureaucratic legerdemain, disappear when office procedures are mentioned.

Hence, there are more in-hospital procedures which are easier on the surgeon and more lucrative to boot. Paul Allen, director, Medical Services Administration, says that "50 hospitals in this state, mostly in southwest Michigan, account for 65 percent of Medicaid patient days and more than 72 percent of the available dollars. Ten of these hospitals receive 35 percent of the more than $500 million we expect to spend this year in hospital care."

The proposal attempts to address those concerns.

I am PRO a plan that attempts to equalize reimbursement for services regardless of the setting in which they are rendered. The physician must be paid the same whether his address is the HCI, the Ford Clinic or 4727 St. Antoine, provided proper documentation is present.

I am PRO a plan that allows a recipient to identify with the physician who has an ethical responsibility and adequate financial remuneration for providing continuity of care; one who helps the patient avoid costly and unnecessary use of the emergency room for non-emergent care. This proposal could reduce doctor shopping and duplication of services.

I am PRO a plan that endorses and reiterates its strong support of the continuing activities of the MSMS Medicaid Liaison Committee and its efforts to identify suspected cases of physician abuse. I support further the plan's intent to work with the Department of Social Services and the legislature in strengthening administrative sanctions against proven cases, even to offer to help in amending PA 321 in this regard.

I am PRO a plan that strives to retain fees for service practice as a viable alternative method of health care delivery. In spite of popular allegations that fee for service whets the rapacious appetite of physicians for financial gain and pushes them to provide more, perhaps unnecessary care, there is good evidence that *"greater use of private practitioners should reduce Medicaid expenditures because unit costs are less."* That is a quote from an interesting article by Stephen Davidson of the University of Chicago.

Lastly, I AM PRO a plan that reemphasizes and acknowledges the paramount role of the physician in the implementation of any reimbursement system.

In spite of the proliferation of health care delivery experts and social engineers, the plain fact is that the legislature, the DSS and the physician must work together dispassionately. No plan will work without physician participation. This plan, I think, will provide that forum.

I ENDORSE IT.

Cecil R. Jonas, MD

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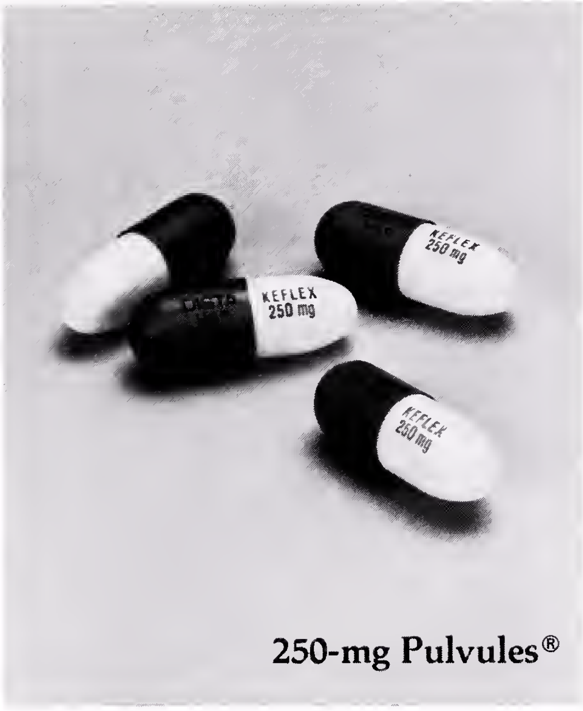

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Doctor Cerny

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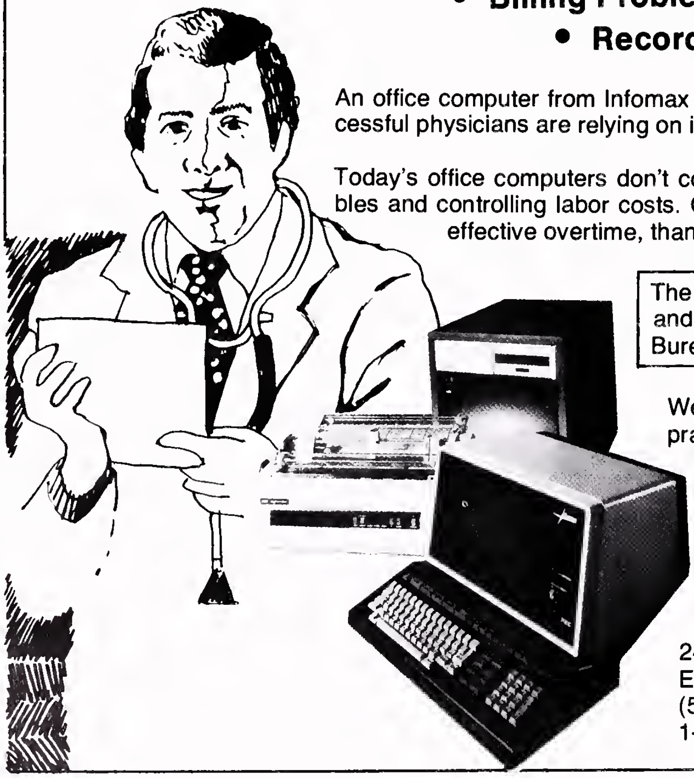
Get Michigan Healthy Again!" is the campaign slogan of **Walter Long, MD**, Homer, candidate in the U.S. House of Representatives race. A 24-year resident of Michigan, Doctor Long has been active in local politics for several years, serving on the Village Council and as Calhoun County GOP Chairman. . . . **Allan Wilke, MD,** St. Joseph Hospital resident family physician, recently was named a recipient of the Mead Johnson Award for Graduate Education by the American Academy of Family Physicians. He is one of only 20 physicians to receive the award, which is given annually to outstanding second-year family practice residents. Doctor Wilke is a graduate of the Michigan State University College of Human Medicine. . . . New president of the Michigan Branch of the American Urological Association is **Joseph C. Cerny, MD,** chairman of Henry Ford Hospital's Department of Urology. Doctor Cerny, an Ann Arbor resident, is a recognized authority on adrenal surgery, treatment of cancer of the prostate and urologic aspects of kidney transplantation. . . . **Robert M. Heavenrich, MD,** is one of four Saginaw citizens honored recently for their volunteer efforts on behalf of the community. Doctor Heavenrich, a pediatrician, was honored for his commitment to children, families, community and profession by the Voluntary Action Center, a United Way agency. . . . Professor and chairman of immunology and microbiology at the WSU School of Medicine, **Noel Rose, MD,** was presented with a Distinguished Service Award during the medical school's commencement ceremony recently. . . . **Choichi Sugawa, MD,** associate professor of surgery at WSU, was presented a 1982 Board of Governors Faculty Recognition Award. An internationally recognized authority on gastrointestinal endoscopy, Doctor Sugawa was also a special lecturer to the 24th Congress of the Japan Gastroenterological Endoscopy Society recently. . . . Other Wayne State University School of Medicine faculty members in the news include **Liborio Tranchida, MD,** and **Vainutis Vaitkevicius, MD,** both selected as judges for the International St. Vincent Prize, awarded every four years to the most prominent contributor in the field of medical science; **Kamran Moghissi, MD,** program chairman of the recent meeting of the American Fertility Society in Las Vegas; **Alexander Walt, MD,** new American Board of Surgery representative on the American Board of Medical Specialties, and new American College of Surgeons representative to the Council of Medical Specialty Societies; **Samuel Gershon, MD,** chairman of a session at the annual meeting of the American Psychiatric Association in Toronto, and **Elliot Luby, MD,** lecturer at that meeting.



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Feeling well rested in the morning usually means having slept well the night before. And for insomniac patients receiving hypnotic therapy, a good morning also means awakening with few side effects from their medication. Many physicians choose Dalmane for their patients who suffer from insomnia for this very reason.

Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.[1] In a double-blind crossover study of 42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.[2] This difference was highly significant ($p<0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.[3]

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.[4] The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.[5-8] Since the risk of oversedation, dizziness, confu-

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Contemporary Hypnotic Therapy '82

sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.[1] Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.[9,10] However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.[11] When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

References: **1.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **3.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **4.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Meyer JA, Kurland KZ: *Milit Med 138*:471-474, Aug 1973. **6.** Feffer HL, Gibbons B: *Med Times 101*(8):130-135, Aug 1973. **7.** Jacobson A *et al*: *Psychophysiology 7*:345, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 1978. **10.** Kales A *et al*: *JAMA 241*:1692-1695, Apr 1979. **11.** Monti JM: *Methods Find Exp Clin Pharmacol 3*(5):303-326, 1981.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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Photo highlights of the 1982 MSMS House of Delegates

MICHIGAN STATE MEDICAL SOCIETY
1866

Port Huron obstetrician/gynecologist James H. Tisdel, MD, was installed as 1982-83 MSMS president.

Photos by Mert Scholten and Rod Rieser

Chosen MSMS president-elect was Donald K. Crandall, MD, Muskegon surgeon, who strode to the front of the hall to acknowledge his colleagues' accolades.

Doctor Tisdel was sworn in by MSMS Secretary Robert M. Leitch, MD, Battle Creek. In his installation address, Doctor Tisdel called for a reemphasis on the art and grace of medicine

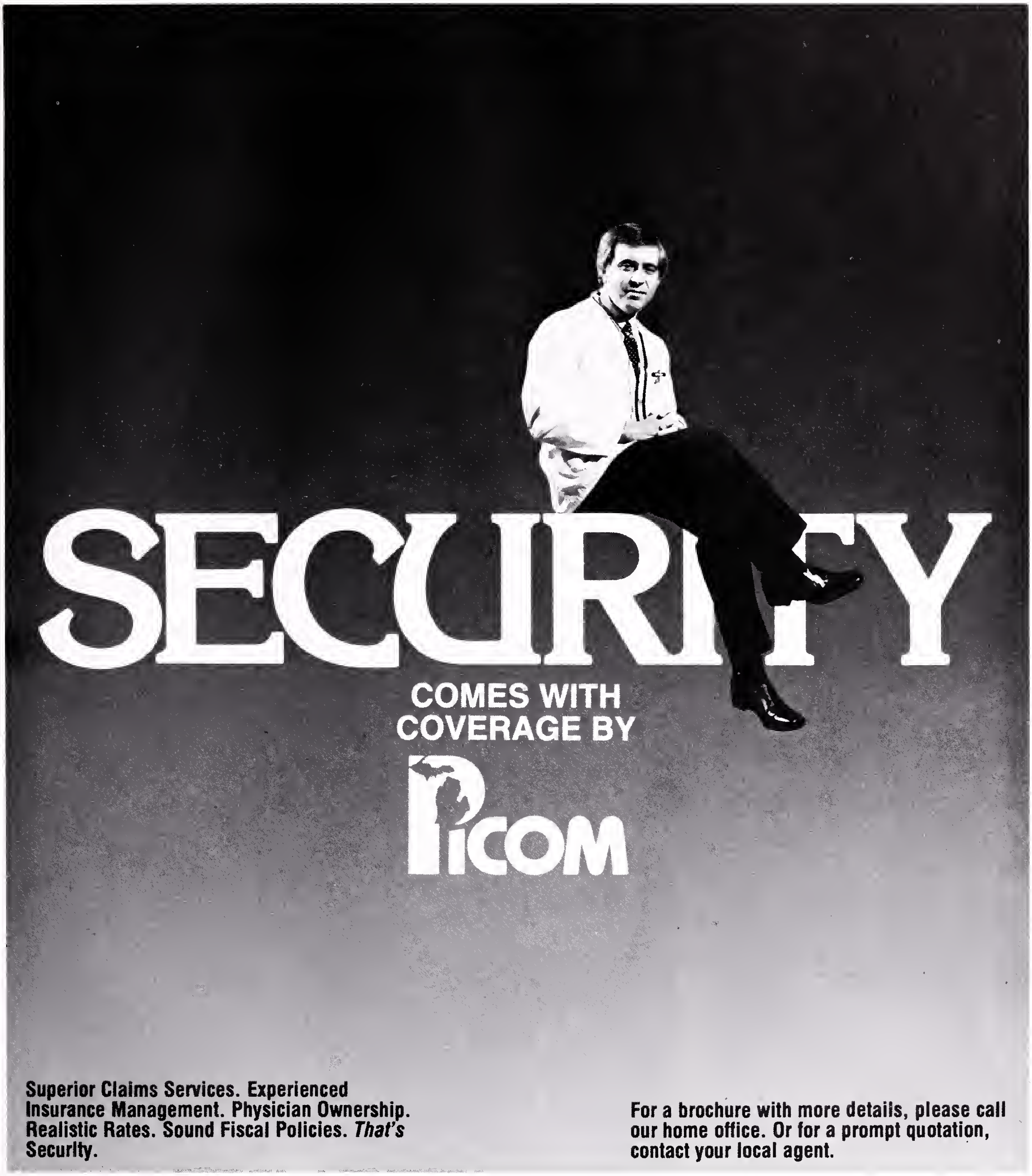
The new 1982 MSMS leadership posed happily for the camera at the MSMS House of Delegates meeting April 30-May 2 in Detroit. From left, they are MSMS President-elect Donald K. Crandall, MD, Muskegon; MSMS President James H. Tisdel, MD, Port Huron; Council Chairman Thomas R. Berglund, MD, Portage; Council Vice Chairman Carl A. Gagliardi, MD, Dearborn; Speaker of the House Gerald H. Mandell, MD, Detroit, and Vice Speaker Robert D. Burton, MD, Grand Rapids.

MSMS Past President Kenneth H. Johnson, MD, Lansing, left; and former MSMS Councilor Frank B. Bicknell, MD, Grosse Pointe, left center, were among the Michigan physicians honored on their 50th anniversary of graduation from medical school. They chatted at the 50-year Reception with MSMS past presidents John J. Coury, MD, Port Huron, right center, and John R. Ylvisaker, MD, Pontiac.

THE WESTIN HOTEL
Renaissance Center

AMA Board Chairman Joseph F. Boyle, MD, Los Angeles, met with the MSMS Council at its pre-House of Delegates meeting, and then addressed the full House.

(More photos on page 398)



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The only 1982 MSMS Presidential Citation was presented during the House of Delegates meeting to Irene H. (Mrs. L.G.) Auberlin, Detroit, president and founder of World Medical Relief, Inc. Mrs. Auberlin received the award from 1981-82 MSMS President James D. Fryfogle, MD.

An MSMS National President's Award was presented to Clara Raven, MD, Detroit, president of the Michigan Chapter, American Medical Writers Association.

THE WESTIN HOTEL
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With characteristic exuberance, Michigan State University College of Human Medicine Dean W. Donald Weston, MD, hugged the glasses off MSMS Auxilian Dorothy Csonka, who presented each of the medical schools a check from the AMA Educational Research Fund, a major auxiliary project.

Also on hand to accept the AMA-ERF donation was University of Michigan Medical School Dean John W. Gronvall, MD. Doctor Gronvall spoke for all the schools when he described their gratitude for the no-strings-attached funds.

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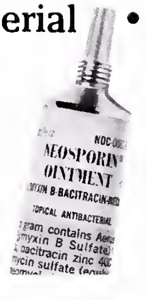

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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Emel Abdulkadir, MD PD
900 Woodward Ave.
Pontiac 48053

Nick C. Adolfo (student)
1301 Orleans #812
Detroit 48207

Timothy B. Aiken, MD OPH
1021 Kearney St.
Port Huron 48060

Gregory J. Anderson, MD FP
420 S. Bower
Greenville 48838

Harry L. Anderson, III (student)
1080 Island Drive Ct. #103
Ann Arbor, MI 48105

Kenneth Backstrand (student)
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St. Clair Shores 48080

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Grosse Pte. Park 48230

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Ann Arbor 48104

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Detroit 48219

Bernd G. Barthel (student)
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East Detroit 48021

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Detroit 48207

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Continued on page 407

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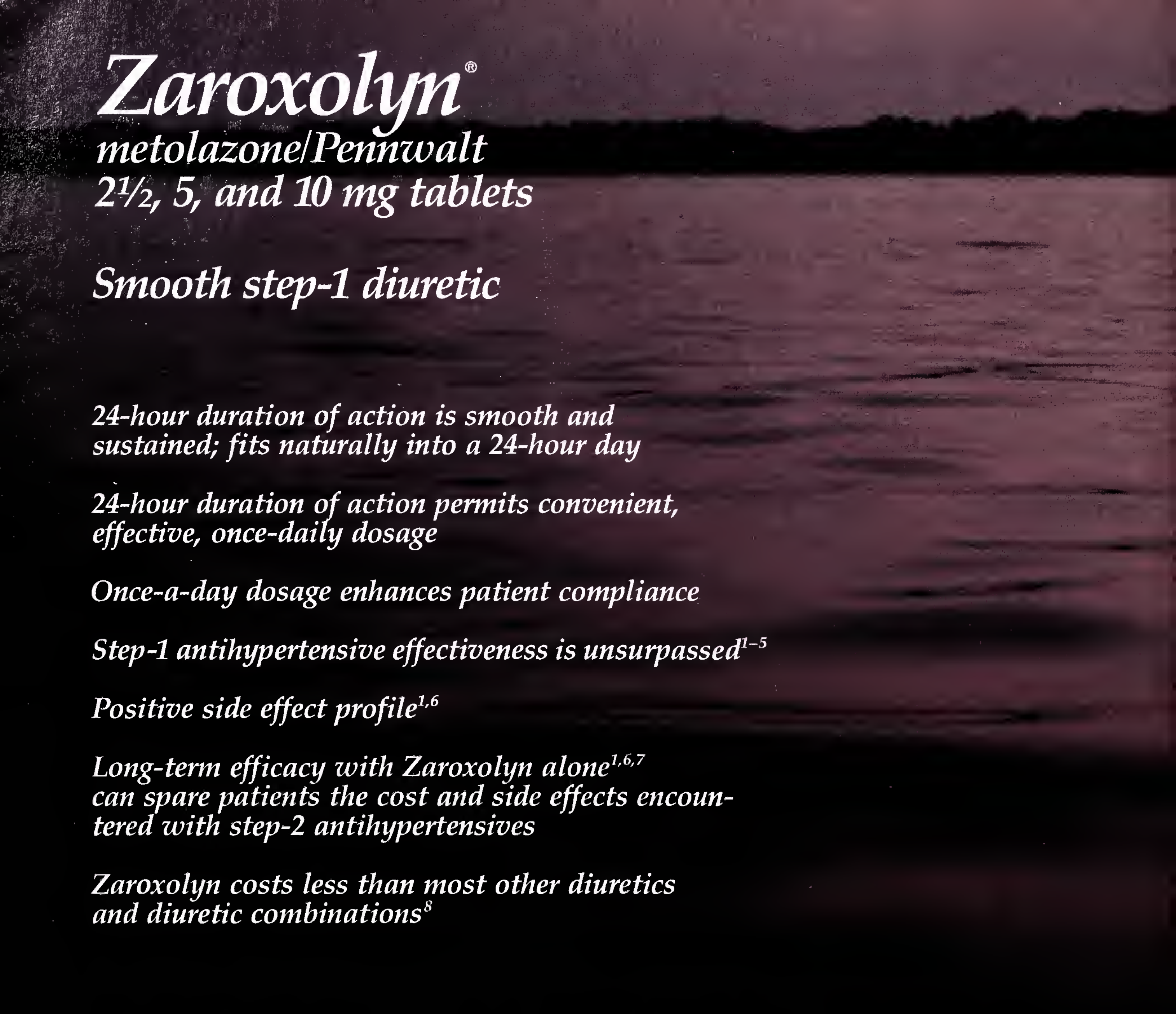

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Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of child-bearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

A-312 3/82

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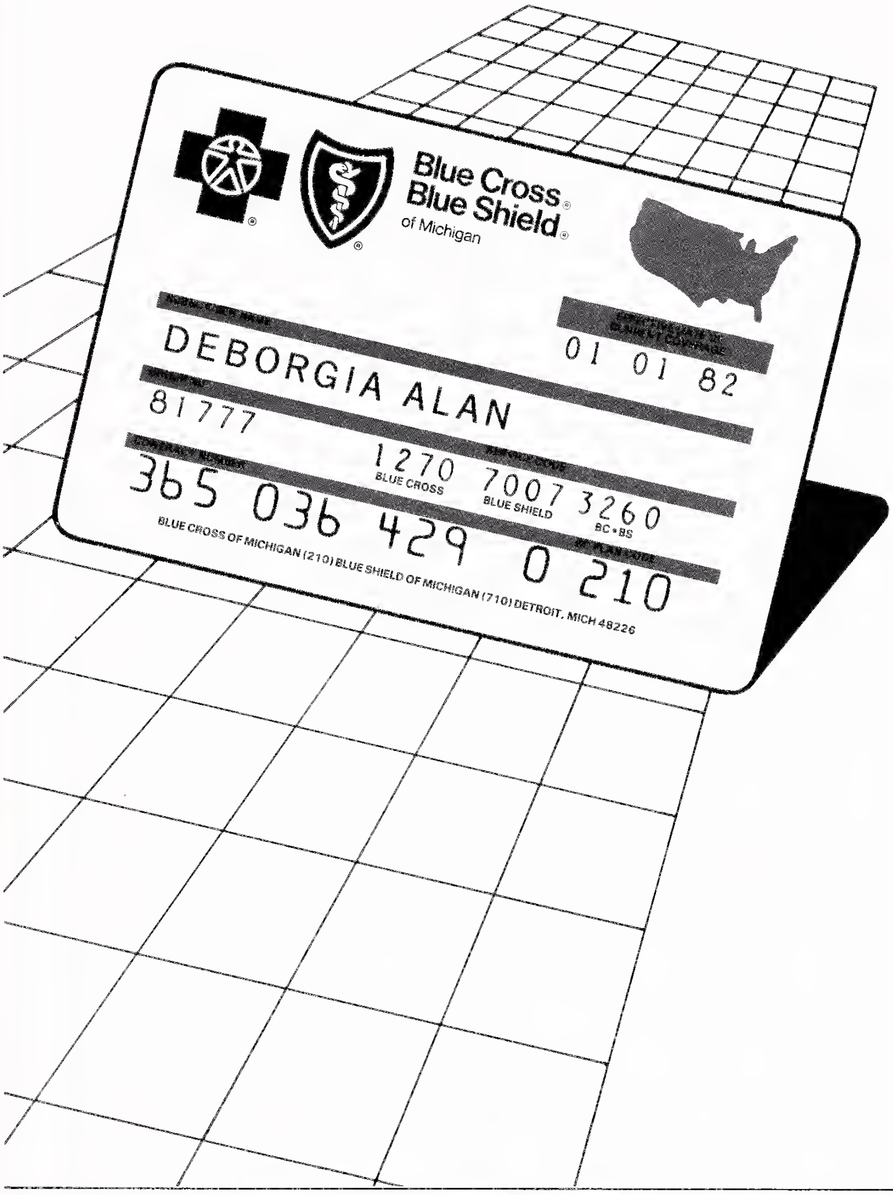
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***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: July 22-25, Fourteenth Annual Summer Conference — Update for General Practice Ophthalmologists. Location: Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Cost:** $150. **Contact:** Leslie E. Meissner, MOS Administrative Assistant, (313) 839-3011. **Approved for:** 8 hours of Category I Credit.

Date: July 22-26, Intermediate Course on Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: July 25-28, Internal Medicine Update. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan, Office of CME, Department of Postgraduate Medicine and Health Professions Education, and the Department of Internal Medicine. **For:** Internists and other primary care physicians. **Cost:** $255. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 11 hours of Category I Credit.

Date: July 29-30, Sixty-Second Annual Coller Penberthy Thirlby Medical Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center Continuing Education. **Cost:** $50. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, Traverse City 49684 (616) 947-6140, Ext. 146. **Approved for:** 9 hours of Category I Credit.

Date: July 30-Aug. 1, Arrhythmias and Cardiac Ischemia: Diagnosis and Management. Location: Boyne Mountain Resort, Boyne City. **Sponsor:** International Medical Education Corporation. **For:** Physicians, nurses and technicians. **Cost:** Physicians — $245, Nurses and technicians — $130. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, 64 Inverness Drive East, Englewood, CO 80112 (303) 773-1144 or 800-525-8646. **Approved for:** 13 hours of Category I Credit.

Date: Aug. 10-14, Emergency Care 1982: Critical Updates in Cardiology, Neurology, and Toxicology. Location: King Edward Hotel, Toronto. **Sponsor:** University of Michigan Office of CME, Dept. of Postgraduate Medicine and Health Professions Education and the Dept. of Emergency Medicine. **For:** Emergency care providers. **Cost:** $395. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 23.5 hours of Category I Credit.

Approved for: 23.5 hours of Category I Credit.

Date: Aug. 18-20, High Risk Obstetrics: The Malformed Fetus. Location: Sea Pines Plantation, Hilton Head Island, South Carolina. **Sponsor:** University of Michigan Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education. **Cost:** $185. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 9 hours of Category I Credit.

Date: August 21, Ethics, The Law, and Medicine: Who's Charge Here? Location: Fairlane Manor, Dearborn. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $95. **Contact:** Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, University of Michigan, Ann Arbor 48109, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: Aug. 23-27, Tutorial on Direct Action Thrusting. Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: August 25, Dermatology for the Practitioner: New Developments. Location: Towsley Center, University of Michigan, Ann Arbor. **Sponsor:** U-M Office of CME, Department of Postgraduate Medicine and Health Professions Education. **For (Specialty):** Family and general practitioners, internists, pediatricians, emergency physicians and all other health care professionals who need practical approaches to the management of common skin problems. **Cost:** $95. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 8 hours of Category I Credit.

Date Aug. 27-30, Advances in the Management of Infectious Diseases. Location: The Grand Hotel, Mackinac Island. **Sponsor:** Department of Internal Medicine and Office of CME, Department of Postgraduate Medicine and Health Professions Education, U-M. **For:** Internists, family physicians, pediatricians and other primary care physicians. **Cost:** $255. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 11 hours of Category I Credit.

Date: August 28-29, Anatomy and Techniques of Regional Anesthesia. Location: Gordon Scott Hall, Wayne State University School of Medicine. **Sponsor:** WSU Division of CME. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, 9B DRHUHC, Detroit 48210 (313) 577-1180. **Approved for:** 12 hours of Category I Credit.

Date: September 8-9, 1982 Western Michigan Trauma and Critical Care Symposium. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Butterworth Surgical Education and Nursing Departments. **Cost:** $75 for two days or $45 for one day. **Contact:** Beth DeVriendt, Butterworth Hospital, (616) 774-1405. **Approved for:** 12 hours of Category I Credit.

Date: September 9-11, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, Chairman, 290 Blodgett Professional Building, 1900 Wealthy St., SE, Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Sept. 10, "Seventh Annual Cardiac Rehabilitation and Exercise Testing Symposium." Location: Borgess Medical Center, 1521 Gull Road, Kalamazoo. **Sponsor:** Borgess Medical Center/Southwestern Michigan Area Health Education Center. **Cost:** $65. **Contact:** Laura Denman, MS, Cardiac Rehabilitation Institute, Borgess Medical Center, Kalamazoo, 49001 (616) 383-8342. **Approved for:** 7 hours of Category I Credit.

Date: September 10-12, Fifth Annual Court in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Department of Radiology and Department of Postgraduate Medicine and Health Professions Education, The University of Michigan Medical School. **For:** all interested physicians. **Cost:** $275. **Contact:** David Bruce Youel, MD, Director, Office of Continuing Medical Education, Towsley Center, U-M Medical Center, Ann Arbor 48109 (313) 763-1423. **Approved for:** 16 hours of Category I Credit.

Date: Sept. 13-15, Total Joint Replacement in the Upper Extremity. Location: Towsley Center for Continuing Medical Education, U-M. **Sponsor:** American Academy of Orthopaedic Surgeons. **Cost:** $420. **Contact:** Gwen Stewart (313) 764-0221. **Approved for:** 18 hours of Category I Credit.

Date: Sept. 22-25, Fifth National Conference on the Impaired Physician: "Positive Strategies in Physician Coping." Location: Portland, Oregon. **Sponsor:** American Medical Association. **Contact:** Janice Robertson, AMA Department of Mental Health, 535 N. Dearborn St., Chicago 60610. **Approved for:** 19 hours of Category I Credit.

Date: September 24-26, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Sept. 25-26, 10th Annual Medical Meeting. Location: Holiday Inn, Petoskey. **Spon-**

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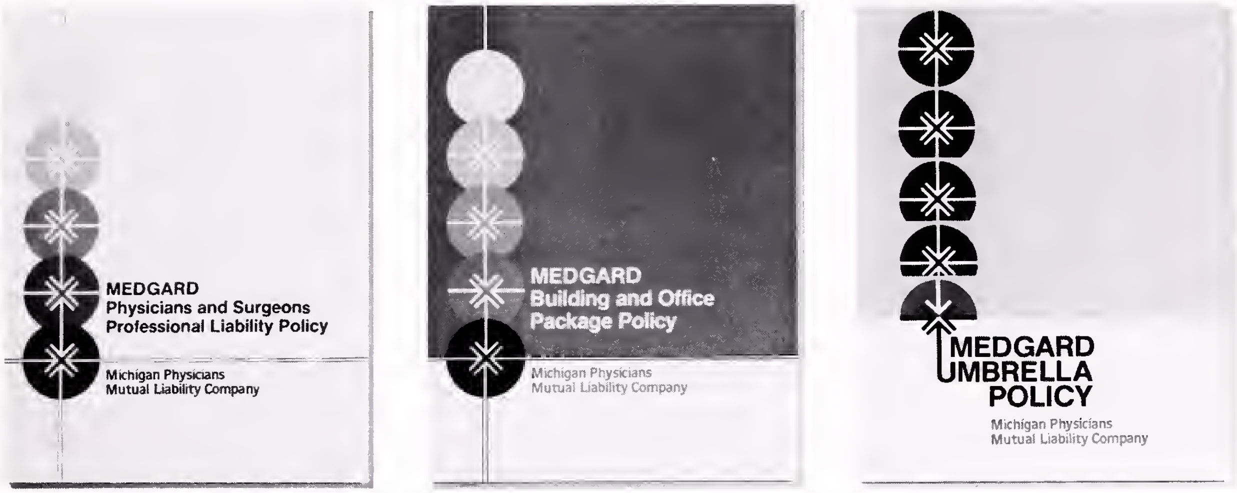

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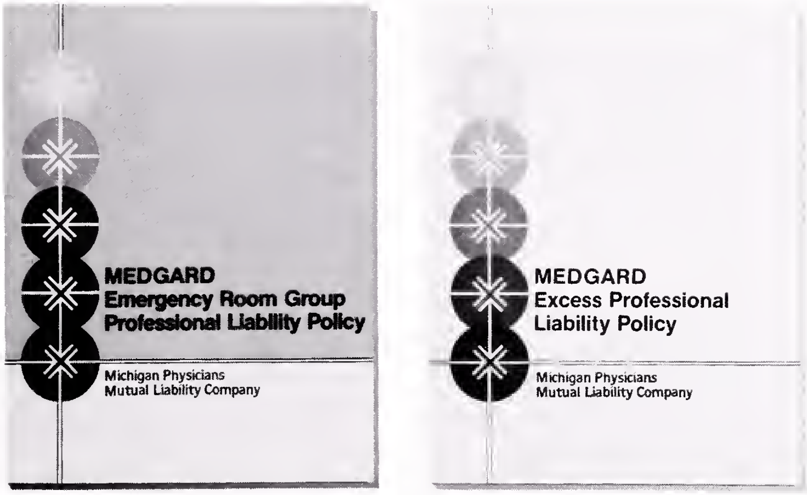

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MEDICAL NEWSFRONTS

As evidence linking hepatitis B virus to liver cancer continues to mount, the use of the newly licensed vaccine against the virus is being seen as a possible way to protect against this single form of cancer, according to an editorial by Harvey J. Alter, MD, in the April 23/30 *Journal of the American Medical Association.*

Alter, who is chief of the immunology section at the National Institutes of Health Clinical Center Blood Bank Department, foresees the possibility that hepatitus B vaccine may become, at least indirectly, the first cancer vaccine. By conferring protection against the hepatitus B virus, it breaks the chain of events that is thought to lead to liver cancer in some people.

Hepatitis B vaccine, which is due later this year, is expected to decrease the incidence of hepatitis B infection and reduce the number of hepatitis B carriers, who are at high risk for developing liver cancer.

The hepatitis B vaccine is made of hepatitis B surface antigen obtained from the blood of carriers. Targets for the vaccine will be people whose jobs, living conditions, sexual practices and medical status put them at high risk for exposure to the disease.

There are an estimated 200 million hepatitis B carriers worldwide, with a high incidence in Africa, Southeast Asia and parts of South America. "The greatest potential use of the vaccine is in the developing nations of the Third World," Alter says. But the vaccine's high cost, a consequence of the long and complicated manufacturing process, could make it inaccessible to the populations that need it most, he warns.

An anti-cancer drug that was synthesized and developed by a University of Michigan pharmacy researcher has been approved by the Food and Drug Administration for evaluation in human cancer patients after a 13-year refinement and testing process.

The drug, tricyclic nucleoside phosphate, was developed by Leroy B. Townsend, PhD, professor of medicinal chemistry, and his colleagues at the U-M College of Pharmacy.

Just how tricyclic nucleoside phosphate attacks cancer is not known, Townsend said, although Linda L. Watring, PhD, assistant professor of medicinal chemistry, has been studying the mechanism of action for over four years.

Several Hospitals in the Detroit area have initiated a program whereby health care professionals are admitted for in-patient psychiatric treatment on a priority basis. Each hospital will exchange services, so that an impaired health care professional can *seek treatment outside of the institution at which he/she is employed.*

The priority admitting agreement by which these professionals are admitted ahead of others on a waiting list is justified on the basis of improved patient care, as *patients benefit* when health care professionals are restored to their practice through prompt and effective treatment.

Participating hospitals include: Cottage Hospital of Grosse Pointe Farms, William Beaumont Hospital of Royal Oak, Sinai Hospital of Detroit and Oakland Hospital of Dearborn.

In a related development, the Wayne County Medical Society's Health and Well-being Committee, chaired by Douglas Sargent, MD, JD, has recently initiated a confidential telephone consultation service for those seeking help and advice for impaired physicians.

CATEGORY I/*Continued*

sor: Burns Clinic Medical Center. **Cost:** $120. **Contact:** Philip E. Hills, MD, Chairman, Burns Clinic Medical Center, Petoskey 49770 (616) 348-4500. **Approved for:** 12 hours of Category I Credit.

Date: October 13, First Kalamazoo Vascular Symposium. Location: Kalamazoo Hilton Inn. **Co-sponsor:** Regional Vascular Surgery, PC and Southwestern Michigan Area Health Education Center. **Contact:** Charles L. Zeller, Jr., M.D., Director, Continuing Medical Education, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo 49001, (616) 388-7877. **Approved for:** 5-6 hours of Category I Credit.

Date: Oct. 14-17, Annual Regional Meeting of the Michigan Chapter, American College of Physicians. Location: Traverse City Hilton. **Sponsor:** American College of Physicians, in association with the Michigan Society of Internal Medicine. **Contact:** Arnold R. Axelrod, MD, Sinai Hospital of Detroit, (313) 493-5780. **Approved for:** 25 hours of Category I Credit.

Date: October 15-16, Cardiac Rehabilitation. Location: Hyatt Regency Dearborn. **Sponsor:** International Medical Education Corporation. **Cost:** $245. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive East, Englewood, CO 80112 800-525-8651 or 303-740-8445, ext. 123. **Approved for:** 13 hours of Category I Credit.

Date: Oct. 25-29, Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Nov. 1-5, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Kellogg Center, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Nov. 8-10. Manual Medicine to the Extremities. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Nov. 20, Surrogate Mother Symposium. Location: McGregor Memorial Conference Center, Wayne State University, Detroit. **Sponsor:** WSU Schools of Medicine and Law. **For:** OB/GYNs and others interested in fertility issues. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 7 hours of Category I Credit.

Date: Dec. 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

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MEETINGS

of MSMS, MSMS/A, AMA, and medical assistants

July 17-18 — Medical Assistants Summer Seminar, Spring Lake Holiday Inn, Spring Lake, contact: Caroline Rich, MSMS headquarters.

July 18 — MSMS/INTRAV Alpine Adventure (15 days), contact: Marce Ireland, MSMS headquarters, 517/337-1351.

July 28 — Council Meeting, Michigan Chapter, American College of Surgeons, Park Place Hotel, Traverse City, contact: Vi Heins, MSMS headquarters, 517/337-1351.

July 28 — Michigan Society of General Surgeons Board Meeting, Park Place Hotel, Traverse City, contact: Caroline Rich, MSMS headquarters, 517/337-1351.

July 30-Aug. 1 — Upper Peninsula Medical Society and Auxiliary Meeting, Marquette, contact Caroline Rich, MSMS headquarters, 517/337-1351.

Aug. 20-22 — National Convention, Physicians of India Association, Detroit, contact: Doctor Kothari, 313/644-1269. Scientific & Academic Meeting to be held Aug. 21, contact: Doctor Ravindranath, 313/644-7725.

Sept. 16-30 — MSMS/INTRAV Far East Adventure, contact: Marce Ireland, MSMS headquarters, 517/337-1351.

Sept. 20 — MSMS/A State Board Meeting, MSMS headquarters, contact Caroline Rich, 517/337-1351.

Sept. 22-25 — AMA Fifth National Conference on the Impaired Physician, Portland Marriott, Portland Oregon, contact: AMA, 312/751-5109, 535 N. Dearborn, Chicago, IL 60610.

Oct. 1-14 — MSMS/INTRAV Nile River Adventure, contact Marce Ireland, MSMS headquarters, 517/337-1351.

Oct. 10-12 — MSMS/A National Leadership Confluence, Drake Hotel, Chicago, contact Caroline Rich, MSMS headquarters, 517/337-1351.

Oct. 28 — MSMS Leadership/Public Affairs Conference, Long's Convention Center, Lansing, contact: Bill Madigan or Kevin Kelly at MSMS headquarters.

Nov. 8 — MSMS/A State Board Meeting, MSMS headquarters, contact: Caroline Rich, 517/337-1351.

Nov. 9-10-11 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Other meetings

July 19-21 — Skills in Health Promotion Series 1982, sponsored by the Michigan Department of Public Health to prepare participants to develop workshops in smoking cessation, stress management and weight control, Park Place Hotel, Traverse City, contact: Office of Health Education, 3500 N. Logan, Lansing 48909, 517/373-9437.

Sept. 9-10 — National Meetings on Physician Maldistribution, sponsored by the U-M School of Public Health, contact Department of Conferences and Institutes, U-M Extension Service, 412 Maynard Street, Ann Arbor 48109.

Sept. 9-10 — National Meeting on Physician Maldistribution, sponsored by the Physician Distribution Incentive Project of the U-M School of Public Health, Westin Hotel, Detroit, contact: Dept. of Conferences and Institutes, U-M Extensive Service, 412 Maynard Street, Ann Arbor 48109.

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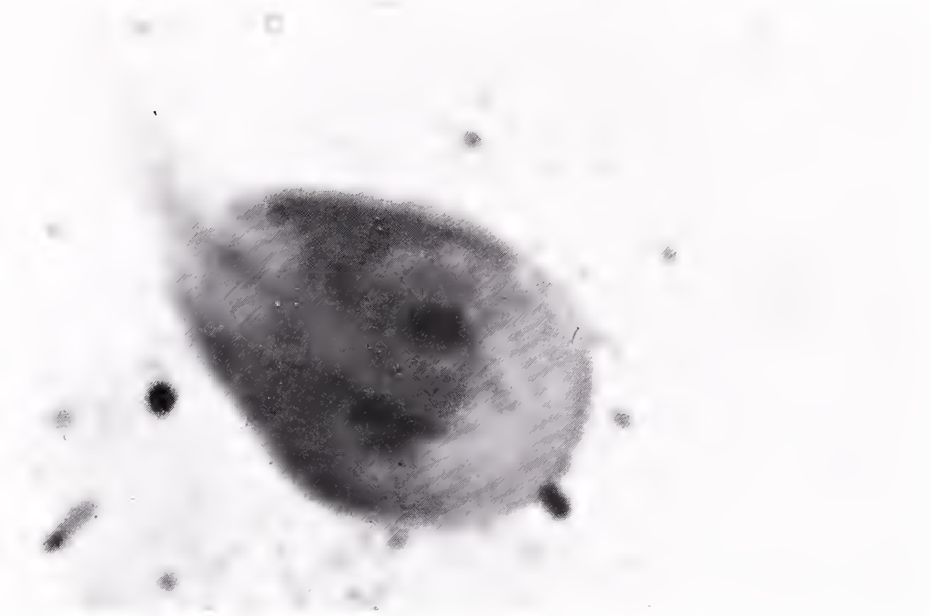

Giardia lamblia

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DEATHS

James H. Ballard, MD
Cass City

James H. Ballard, MD, Cass City general practitioner, died April 30. He was 65. Doctor Ballard earned his medical degree in 1943 from the University of Michigan, and served as a captain in the Army Medical Corps. during World War II. A former chief of staff at Hills and Dales Hospital in Cass City, Doctor Ballard was one of the Thumb area's foremost "country doctors" for more than 35 years.

J. Donald Flynn, MD
Grand Rapids

J. Donald Flynn, MD, Grand Rapids, died May 14 at the age of 75. Doctor Flynn, an otolaryngologist, received his MD from the University of Michigan in 1935, and served in the U.S. Navy from 1942 until 1946. During his 40-year career in Grand Rapids, Doctor Flynn was affiliated with Blodgett Memorial Hospital, St. Mary's Hospital and Mary Free Bed Guild Children's Hospital. He was an active volunteer for 32 years at the latter hospital, as well as at Shawnee Park Oral and Deaf School.

Edson H. Fuller, MD
Grand Rapids

Edson H. Fuller, MD, Grand Rapids general practitioner, died April 30 at the age of 72. Doctor Fuller served his internship at Butterworth Hospital after receiving his MD from the University of Rochester in 1935, and maintained an affiliation with Butterworth, St. Mary's and Blodgett Hospitals throughout his career. He was honored in 1963 for 20 years of service to the Selective Service System, for which he had examined inductees since WWII. Doctor Fuller was a past president of the West Michigan Chapter of the American Academy of General Practitioners.

Willard N. Hayes, MD
Norway

Willard N. Hayes, MD, of Norway, died April 20 at the age of 65. Doctor Hayes graduated from the University of Michigan Medical School in 1942, then served as an intern at Harper Hospital. He saw military duty in China, Burma and India from 1943 until 1946 with the Army Medical Corps. Named Dickenson County "Citizen of the Year" in 1968 by the Lions Club, Doctor Hayes was active in 4-H and on the local board of education. He maintained a 35-year association with Anderson Memorial Hospital.

Leonard P. Heath, MD
Detroit

Leonard P. Heath, MD, Detroit obstetrician/gynecologist, died April 20. He was 75. Doctor Heath earned his MD at Wayne State University in 1934, then served as an intern and resident at Harper Hospital. A lieutenant colonel in the U.S. Army from 1942-45, Doctor Heath was a former chairman of the Department of OB/GYN at Harper Hospital, and a clinical associate professor of OB/GYN at the WSU School of Medicine. He was a past president of the Michigan Society of Obstetricians/Gynecologists, and a member of the American College of OB/GYN, the American College of Surgeons, the Central Association of OB/GYN and the Pan-Pacific Surgical Association.

Robert S. Ideson, MD
Ann Arbor

Robert S. Ideson, MD, Ann Arbor general practitioner for more than 35 years, died May 11 at the age of 60. He earned his medical degree from the University of Michigan in 1945, and was a past president of the Washtenaw County Medical Society. Doctor Ideson served the Ann Arbor community as president of the Washtenaw Physicians' Emergency Service, and as an active volunteer in the Lions Club Cancer Society, March of Dimes, and YMCA. He was voted "Outstanding Young Man of the Year" by the Ann Arbor Jaycees in 1955.

Charles J. McKenna, MD
Grosse Pointe

Charles J. McKenna, MD, Grosse Pointe, died March 18. He was 76. Doctor McKenna earned his medical degree from the Detroit College of Medicine in 1932, after completing his pre-medical training at the University of Detroit. He was a general practitioner.

Arthur J. Petz, MD
Livonia

Arthur J. Petz, MD, Livonia, died May 18 at the age of 53. He received his MD from Wayne State University School of Medicine in 1954, and served in the Army in 1956-57. Doctor Petz, an internist, was chief of staff at St. Mary Hospital in both 1974 and 1975. He was a member of the American College of Physicians, the Geriatric Society, and served on the Livonia Commission on Aging.

Anthony C. Porretta, Sr., MD
Lockport, New York

Anthony C. Porretta, Sr., MD, formerly of Detroit, died April 21. He was 80. Doctor Porretta graduated from Wayne State University School of Medicine in 1937. A general practitioner, Doctor Porretta was a member of the Michigan Health Officers Association, and the Michigan Public Health Association, Inc.

Wendell H. Stadle, MD
Sun City, Arizona

Wendell H. Stadle, MD, formerly of Battle Creek, died April 30 at the age of 79. He earned his MD from Northwestern University in 1927, then served in the U.S. Navy Medical Corps during WWII. An obstetrician/gynecologist, Doctor Stadle was on the staff of both Community and Leila Hospitals of Battle Creek. He had served on the Calhoun County Metropolitan Planning Commission. Doctor Stadle retired from his medical practice in 1952, then pursued his hobby of collecting automobiles. He had served as president of the Veteran Motor Car Club of America.

Richard K. Vaught, MD
Bloomfield Hills

Richard K. Vaught, MD, Bloomfield Hills, died May 1. He was 51. Doctor Vaught graduated from the Wayne State University School of Medicine in 1957, and served in the U.S. Navy during the Korean conflict. He maintained a family practice in Troy and Royal Oak for more than 25 years, and was affiliated with Beaumont, Community, and Crittendon hospitals in that area. Doctor Vaught was a member of the American Academy of Family Practice.

DEFLATION

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PHYSICIAN WANTED — Attractive small community in Michigan's Upper Peninsula seeking one or two resident family physicians. Drawing area 12,000. Active recruitment committee made up of medical building and community backed interested citizens. Hospital and medical center within 25 miles. Write to: Mid-County Health Center Association, PO Box 56, Gwinn, MI 49841; or call (906) 346-5413 or (906) 346-5326.

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MICHIGAN TECHNOLOGICAL UNIVERSITY Health Service seeks a replacement primary care Director/Chief of Medical Staff. The health facility is a medically oriented, ambulatory service, servicing a university student population of 7,700. Annual studed allow adequate enjoyment of the rural all-season recreation area. Contact David Schwalm, P.A., Administrator, Michigan Technological University Health Services, Houghton, MI, 49931, or call 906-487-2435. Michigan Technological University is an equal opportunity educational institution/equal opportunity employer.

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FAMILY PRACTICE — S.W. Missouri. Modern and progressive 50 bed hospital. Good coverage and financial guarantees. Small community in the Ozarks close to medium size city. Call Karlman Associates, 680 Beach St., Suite 348, San Francisco, CA 94109 (415) 775-1657.

Miscellaneous

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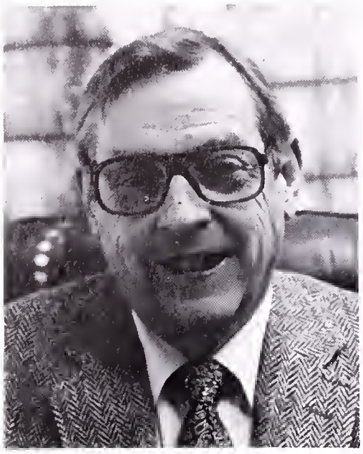

PRESIDENT'S PAGE

We must return to the art of healing

By James H. Tisdel, MD
Port Huron

It has been asked by a well-known consumer advocate, "What has happened to those traditions of the good physicians of the past — the kind, the understanding, the sympathetic, the compassionate? Their small and personal intimacies have lost out to the efficiencies of science and commercialism."

Can we do anything about it? Certainly, we can. We can turn this around by returning to patient-physician and physician-patient relationship — by treating all patients with the same concern, understanding, friendliness and compassion we show our families, neighbors and friends.

We have forgotten the importance of the art of medicine.

My teachers emphasized the importance of caring . . . of listening . . . of compassion. What of the young doctors today — have we given them all the tools to become truly fine physicians?

Are we emphasizing that the primary purpose of medicine is to treat people — men, women and children — not as numbers, but as individuals, one at a time, with all the art, as well as the science and technology, tempered by the greatest wisdom available in each of us?

Are we to become the by-products of the impersonal third party payor system which allows physicians to treat patients with little regard for their person — because someone else will pay for the services?

We must reemphasize the spirit of humanity and concern which is implicitly necessary for the complete practice of medicine.

William Cowper wrote —

"Knowledge and wisdom far from being one, have oft times no connection —
Knowledge wells in heads replete with thoughts of other men,
Wisdom in minds attentive to their own.
Knowledge is proud that he knows so much;
Wisdom is humble that he knows no more."

Society has come to have great expectations of our profession. Is this one of many reasons for our problems with malpractice claims — too many of us viewed as materialistic instead of idealistic? It is a known fact that patients are more reluctant to sue a concerned physician than one perceived to be unconcerned and uncaring. Let us treat our patients with all the skill, care and empathy we possess. No matter how fine our training — despite the greatest knowledge and skill and the soundest medical judgment — the prognosis, the outcome of disease, is often subject to uncertainty. Because all these things can be true, communications between doctor and patient are of the essence. Let patients and families know we care about them.

Gerald Schiebler, M.D., head of the Department of Pediatrics at the University of Florida Medical School in Gainesville stated my point well. He wrote in February of 1979 "The Art of Being Gracious," in which he said:

> "Everyone would like to be a gracious person. Graciousness is a precious attribute of most of the things we yearn for — admiration, respect, love and happiness. It is a mistake to think that one is born with this attribute. It is an acquired trait, as readily acquired as good manners, which constitute a very important part of it. But unlike most arts, one does not need to have a special talent for it. Only the sincere desire to be gracious — plus thoughtfulness and practice — are required.
>
> "The key to the art is the Golden Rule — applied so consistently that it becomes natural. It is a matter of treating others the way you would like to be treated — not because it is the diplomatic thing to do but because you want to treat them that way.
>
> "The art of being gracious is developed by doing kind things — and sometimes difficult things — in the kindest way, until such behaviour becomes characteristic for you. And how rewarding such a grace can be! Wordsworth declared that such little, nameless, unremembered acts of kindness add up to the best portion of a good man's life."

The founders of all our great religions and religious traditions are healers. Miracles of healing started and established religion. As physicians, we must return to healing, not only by science and technology, but by the art. We must possess knowledge first and only later become a person of wisdom and skill. Thus we have the essential ingredients in the practice of the truly noble physician.

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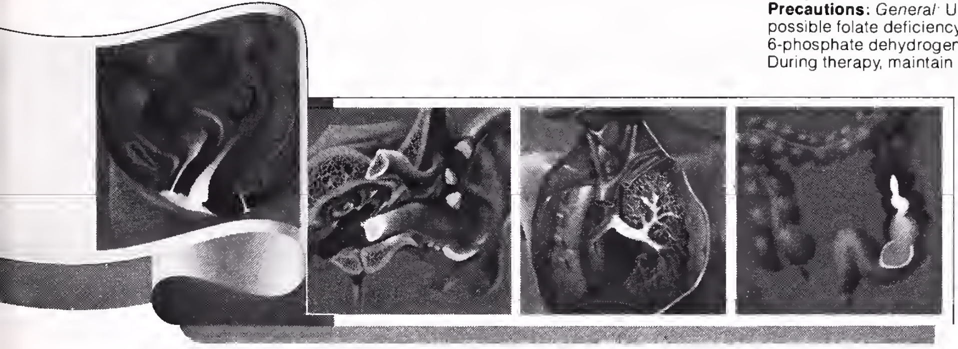

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For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
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Adults. Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
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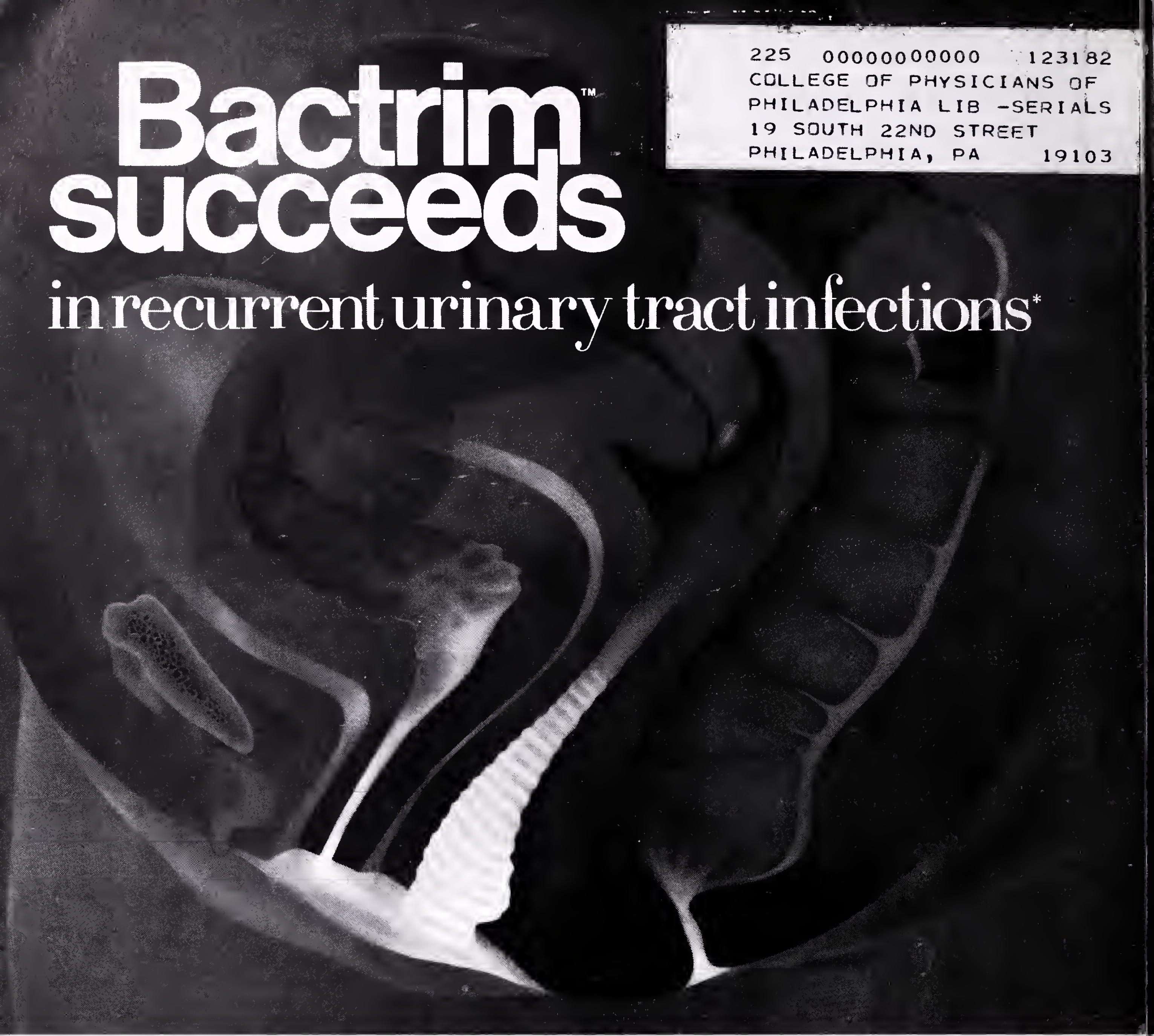

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1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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* due to susceptible strains of indicated organisms

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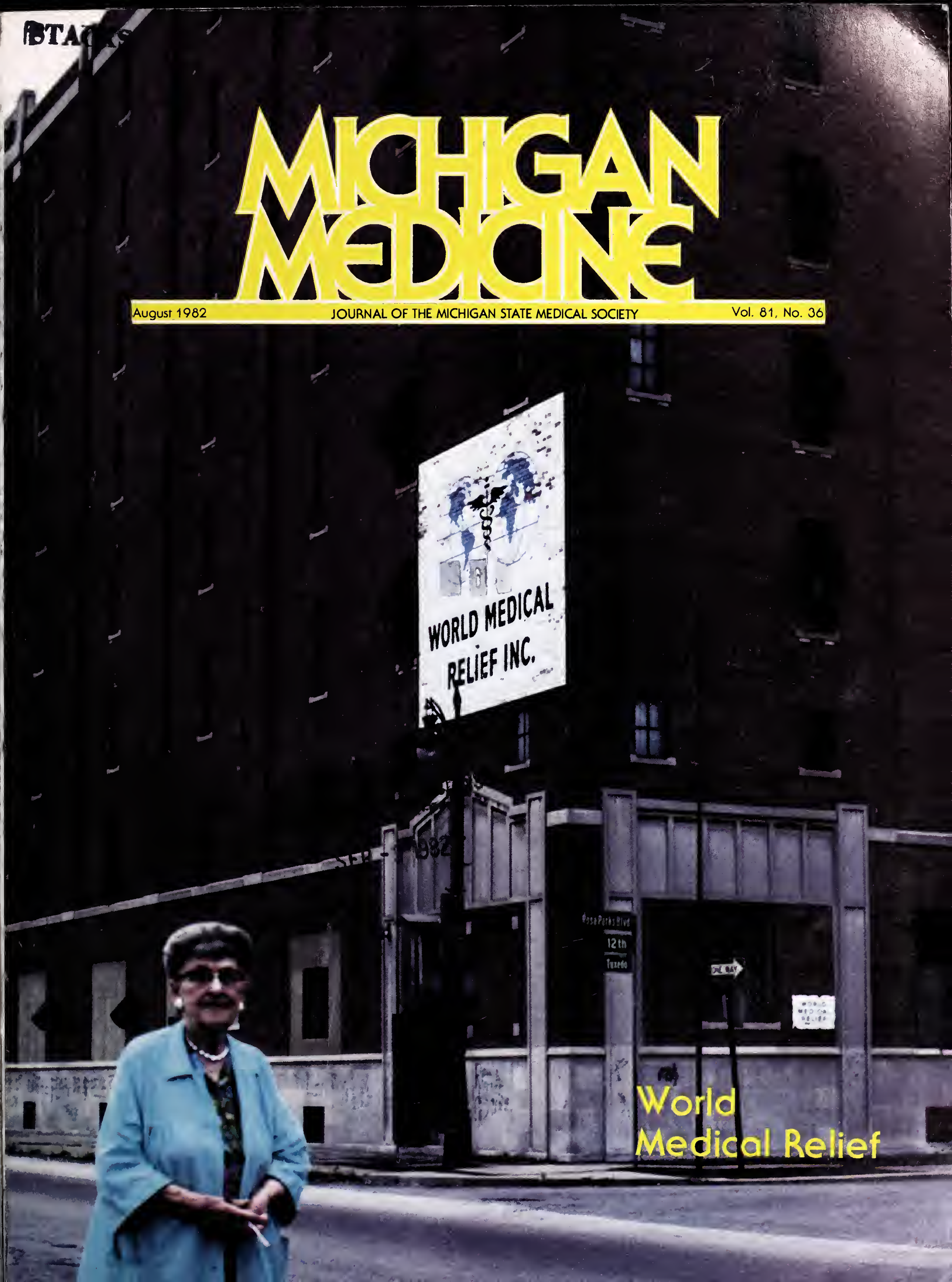
August 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 81, No. 36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On this month's cover, Irene Auberlin and the eight-story warehouse of World Medical Relief, Detroit. The photograph spotlights the second of a two-part series on physicians' humanitarian service. **(Photo by Mert Scholten, MSMS staff)**

WDS

MICHIGAN MEDICINE

August 1982, Volume 81, No. 36

Special report

428 In this second of a two-part series on Michigan physicians' humanitarian services, *Michigan Medicine* spotlights World Medical Relief, Inc., of Detroit, and its dynamic founder and president, Irene G. Auberlin. Mrs. Auberlin is the indomitable 85-year-old who received the only Presidential Citation awarded by MSMS this year. Her organization, which has provided free medical supplies and equipment to the needy of the world for nearly 30 years, is the first group officially endorsed and supported by the new MSMS Committee on Humanitarian Services. When you have finished reading this article, we hope you will be moved to share your surplus stores of medications and equipment and those of your hospital, with World Medical Relief. Ultimately, you then will be helping the sick and destitute WMR serves; Judith Marr

Features

434 For better insight into the uses and management of the new medical technology, physicians may attend the 1982 Annual Scientific Meeting Nov. 9-11 in Dearborn

436 MSMS forms the Physicians' Review Organization of Michigan (PROM), committed to ensuring the delivery of quality medical care; Kirk McMurray

442 How it feels to pilot the Space Shuttle — Michigan astronaut Jack R. Lousma describes the physical experience of weightlessness and the medical research accompanying development of the Shuttle flights; Willah Weddon

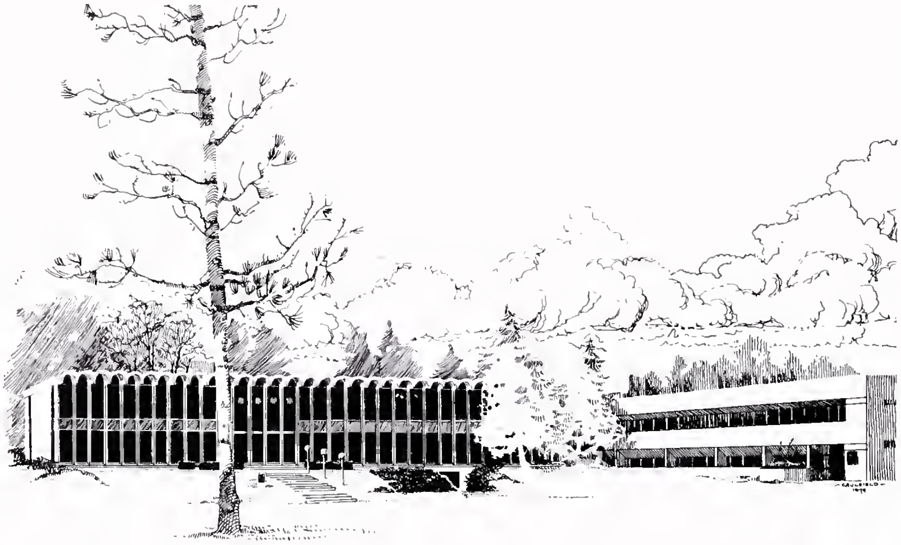
446 Upper Peninsula program strives to attract area residents to practicing medicine at home; J. Michael Coyne, MD, and Jacob Vinocur, PhD

449 Meeting the Challenge of the 80s: communicating with patients and personal goalsetting; part of the continuing MSMS series

454 New guidelines for health care for the elderly; Russell E. Holmes, MD

Departments

425 Letters
456 New members
458 News
465 Views: Robert D. Burton, MD; James D. Fryfogle, MD
470 Medical newsfronts
472 Category I meetings
474 Meetings
476 Deaths
477 Board of Medicine actions
478 Classified ads
479 Advertising index
480 President's page; James H. Tisdel, MD



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Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

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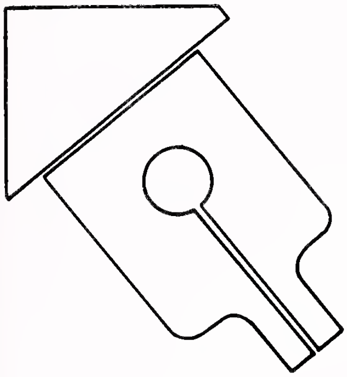
LETTERS



Informed consent

Since the MSMS has called upon the Medical Humanities Program at Michigan State University for several years now to offer a workshop on medical ethics at the fall scientific meeting, we feel obligated to respond to the medico-legal item, "Standard of practice for informed consent upheld in high court," in the May issue, by the MSMS legal counsel A. Stewart Kerr. (Actually, despite what the headline suggests, Mr. Kerr reports that the Supreme Court did not uphold the standard of practice, as the Court refused to consider that issue in its decision.)

In the brief note, Mr. Kerr endorses the professional standard for informed consent and, for reasons never given, rejects the "lay standard" of *Sard v Hardy*, which holds that the physician is obligated to disclose "what a reasonably prudent patient is expected to be told." We must note that, in the growing medical-ethics literature on informed consent, there is virtually no support for the professional-standard rule. Because the underlying purpose of informed consent is to give the patient the opportunity to make an informed, autonomous choice, most authorities agree with a recent work on clinical medical ethics, "The informed consent doctrine requires the physician to provide sufficient information for the patient to be able to make a rational and reasonable decision" (1). This suggests strongly that the appropriate reference standard is what information the patient, as an individual, requires, and not what information is customarily divulged by other physicians.

It may well be that since the Supreme Court did not address the issue of the standard for informed consent, the professional standard is the current *legal* standard in Michigan. We argue that only a patient-oriented standard can give the individual physician proper *ethical* guidance in deciding what sort of information to disclose to patients. Furthermore, if the trend of recent court decisions in other states is any indication, the professional standard may soon be overturned in Michigan in any case(2).

Misunderstanding of the underlying principles of informed consent has engendered a great deal of skepticism and outright hostility among physicians (3,4). In this setting, the customary practice of other physicians cannot adequately serve as a guide for what the individual patient needs and wants to be told. Just to cite one problem area, it is clear that if a physician blindly followed a professional standard, he or she would probably administer to the patient a multi-page form written in technical jargon which 80% or more of the general public would find incomprehensible (5,6). This sort of bureaucratic approach certainly does not promote autonomous and rational decision-making by patients, and in addition fails to provide the protection from legal liability that is probably the motivating force behind such forms to start with. As soon as a "lay standard" is adopted, and the situation viewed from the patient's perspective, the idiocy of such useless forms becomes apparent.

Howard Brody, MD, PhD
Bruce L. Miller, PhD
Medical Humanities Program
Michigan State University

1. Jonsen AR, Siegler M, Winslade WJ. Clinical ethics. New York: Macmillan, 1982, p. 68.

2. Miller LJ. Informed consent: IV. JAMA 244:2661-2, 1980.

3. Laforet EG: The fiction of informed consent. JAMA 235:1579-85, 1976.

4. Cassileth BR et al: Informed consent — why are its goals imperfectly realized? N Engl J Med 302:896-900, 1980.

5. Grundner TM: On the readability of surgical consent forms. N Engl J Med 302:900-2, 1980.

6. Morrow GR: How readable are subject consent forms? JAMA 244:56-8, 1980.

MSMS brochure

Thank you for the new brochures on "If someone in your family wants to become a doctor . . ." It has been gratefully accepted by the students trying to decide on a future career. It presented a very concise general overview of what the practice of medicine would involve. Excellent.

P. Tanhehco, MD
Flint

Medicaid

The following comments are excerpted from a recent letter to Allen Turcke, MD, Chairman, MSMS Medicaid Liaison Committee. They provide an idea of the difficulties in policing the Medicaid program.

This letter is to bring you up-to-date regarding the Medicaid program efforts to control the gross overutilization of office laboratory testing occurring on the part of a relatively small number of physicians. We have previously transmitted to you data describing the extent of office laboratory testing for the 40 physicians doing the most of such testing in each of two separate quarters. . . .

As you know, one of the results of our meeting in December, 1981 with physicians of MSMS and MAOPS, was recommendations that the department either not pay physicians with such patterns of laboratory overutilization, or review the bills very carefully before payment. We then moved to implement a "selective editing" process whereby, for these original "top 40" physicians, all laboratory testing would pend for review before payment. As a part of the review, we would request copies of the medical record that was supposed to support the necessity for such testing. We began to do this toward the end of February and by about the beginning of April, all 40 physicians from our first listing were on selective editing. . . .

Continued on page 438

Candidates for nutritional therapy...

10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socioeconomic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]

Before prescribing, please consult complete product information, a summary of which follows:
Each Berocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.
Contraindications: Hypersensitivity to any component.
Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
Adverse Reactions: Adverse reactions have been reported with specific vitamins and

ROCHE®

5,000,000 hospital patients with infections.[4] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[3]

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.[5]

Berocca Plus
A balanced formula for prophylactic or therapeutic nutritional supplementation.
Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

Berocca Plus, highly acceptable to patients, has virtually no odor or aftertaste and is economical. And its "Rx only" status means more physician involvement, better patient compliance.

References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.
Dosage and Administration: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.
How Supplied: Golden yellow, capsule-shaped tablets—bottles of 100.

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THE MULTIVITAMIN/MINERAL FORMULATION

Special report

MSMS committee adopts World Medical Relief

By Judith Marr
Editor, Michigan Medicine

This is the second in a two-part series of reports on Michigan physicians' humanitarian services. This first part of the series appeared in the July 1982 issue of *Michigan Medicine*, and highlighted Michigan physicians' activities to help care for the unemployed, the ill in underdeveloped nations, and the world populations facing the threat of nuclear war. The MSMS Committee on Humanitarian Service also was profiled. The committee's first major activity is described in this article.

It's a privilege to tell you of the marvelous principle and personality of Irene Auberlin, and the magnitude of the service her organization provides humankind.

Irene Auberlin (Mrs. L.G., widowed since 1974) is the indomitable 85-year-old with snapping eye and firmly-set jaw who graciously accepted the only MSMS Presidential Citation awarded this year. She is the founder and president, the dedicated spiritual sparkplug of World Medical Relief, Inc. The Twelfth Street, Detroit, enterprise annually sends millions of dollars worth of surplus medical supplies and equipment to the needy of the world.

Mrs. Auberlin took the opportunity of the awards presentation before the MSMS House of Delegates meeting in May to make a pitch for those who depend on her organization. There was more than one person there moved to tears by her appeal; she gained considerable support for her medical relief organization.

World Medical Relief also is the first organization officially designated for support and promotion by the new MSMS Committee on Humanitarian Service. Does she feel that official MSMS recognition is long overdue?

Doctors involved

"Oh, my no," she chirped, in that rapid-fire staccato which characterizes her intense energy. "We just want to get the doctors more involved."

Actually, MSMS members are far behind their spouses in support of WMR. Promotion of its causes long has been a project of the MSMS Auxiliary. Mrs. Auberlin took MSMS President James H. Tisdel, MD, Port Huron, and an entourage on a tour this April of her eight-story warehouse facility, preparatory to the MSMS committee's taking on support of World Medical Relief as a project.

I was part of that entourage. Mrs. Auberlin agilely stepped on and off elevators floor to floor, leading us from one staging area to the next of her awesome enterprise.

Our group also included Muriel Tisdel, Doctor Tisdel's wife; Dennis Paradis, staff to the MSMS Committee on Humanitarian Services, which Doctor Tisdel heads, and MSMS Communications Chief Mert Scholten, photographer for the day.

Bemoaning the fact that some of the large drug companies will not provide badly-needed drugs, including anti-malarials, Mrs. Auberlin fired at us, "So that's when we have to resort to a little 'pressure-begging'." She followed that insight with a sheepish grin and a shrug of her shoulders as if to say, "What's a lady to do?"

We all marveled at what that lady does, and joined her in goose bumps as she related the miracles of love and giving she and her staff witness on a regular basis through their work.

Mrs. Auberlin literally lives her work. She sleeps in a cot in the office of the warehouse which houses World Medical Relief. She has other living quarters there, "but I never seem to go in there anymore, I don't know why," she says absently. She has a paid staff of 10 persons. Also living with her is a large, black German shepherd-cross dog Mrs. Auberlin calls "Darlin."

Those 11 persons and "Darlin" supervise the work of 230 volunteers, most of them retired persons, who receive, catalogue, sort, repair, sterilize, package, crate and ship medical supplies to the needy. "Darlin" characteristically knows the word "volunteer" better than her own name.

No narcotics

Two retired volunteer, registered pharmacists, carefully sort, record, verify and package the surplus drugs given to the firm. No controlled substances or narcotics are distributed by WMR overseas.

Free prescription drugs, however, are distributed to needy elderly in the tri-county area with documented proof of income and banking. Surplus controlled substances are carefully disposed of under the watchful eyes of federal officers.

World Medical Relief is deeply involved with several US organizations, including Volunteer Optometric Services to Humanity and its student counterpart, and to date has provided 32,000 plus pounds of used

Could you turn down this wonderful lady? She's Irene Auberlin, founder and president of World Medical Relief, Inc., Detroit. She asks that physicians and hospitals donate their surplus medical supplies and drugs to WMR for shipment to the needy of the world.

Mrs. Auberlin stops at reception desk in WMR office to describe details of the operation to MSMS President Doctor Tisdel. Above them is a map with relief areas pinpointed.

eyeglasses to them. WMR also contributes to Interplast, a Stanford University surgical group which provides free reconstructive surgery for Mexican and Central American children. And WMR has a large program in Bluefield, West Virginia, through the mental health center, where WMR contributes medications for the care of the destitute and sick.

WMR recently has been asked by the State of Michigan to aid all relief organizations in the state, as the worsening economy restricts their financial support. This expands WMR's existing program of filling prescriptions for persons 60 and over who are not on Medicaid or welfare. WMR also provides those persons with sheets, towels, pillow cases, blankets, lap robes, afghans, knee warmers, body lotion, shampoo, household cleaning items and medical supplies.

The floors of the warehouse are stocked with a Stygian jungle of cabinets, surgical lamps, delivery tables, bedpans, syringes, examining tables — all the paraphernalia of medical practice. Much of it is in need of repair; a volunteer staff cleans and restores all to working order in a well-equipped machine and tool shop (all donated) in the warehouse.

Some of the equipment looks positively antique. But, "it's all treasure to a missionary," Mrs. Auberlin said. "They don't have anything."

Three words

Mrs. Auberlin is strongly spiritual. A blackboard near the pharmacy the day we toured read, "Use me, Lord — three words that can change a life."

"You can't work here and not have faith," Mrs. Auberlin told us over and over. She accepted her MSMS award, as she has each of the hundreds of other citations she has been awarded, "in God's name." She and her closest associate, Clara Kohn, who has been with WMR for 20 years, marveled with us at the many miracles of aid they have seen.

There was the cancer victim who recently needed a very expensive drug, which World Medical Relief had little hope of obtaining. The next day, in the center of a carton of drug samples sent by a local hospital, was a supply of the exact drug, in the exact dosage needed.

There was the mission hospital in Pakistan which sent an urgent call for 20 good mattresses, a nearly impossible order for World Medical Relief to fill. But within hours, a Detroit hospital nun with, miraculously, 20 extra mattresses of the exact size needed, telephoned to see if World Medical Relief could use them.

"It happens all the time," marvels Mrs. Auberlin. "We know who really runs WMR."

Every piece of office equipment, lumber for crating, every hour of time worked for World Medical Relief is donated.

Major companies and Detroit leaders have supported and contributed to the organization and continue to do so. Their executives sit on her board, free of charge, and meet for well-scripted one-hour board meetings in the volunteers' second-floor kitchen at the warehouse.

They have recognized the careful, correct organization Mrs. Auberlin manages, and the importance of its work.

The Auberlins founded the organization in 1953, after a personal tragedy Mrs. Auberlin declined to discuss left them looking for a purpose beyond their own lives. A televised appeal to help Korean orphans provided that purpose.

The Auberlins collected vitamins and clothing in their living room for the orphans, and their work snowballed from there.

In 1956, they moved to the Jennings Hospital Annex, a year later to the second floor of an old baking company's horse barn. They outgrew that facility in 1960, and moved into a five-floor warehouse.

WMR moved into its permanent headquarters on 12th Street in 1964. In the midst of the 1967 Detroit riots the Auberlins moved into the warehouse. They went home, got their beds and moved them into the warehouse, as the rioters were threatening to keep them out. They never returned to their home.

Federal, state

World Medical Relief is licensed as a charitable organization by both federal; state and city governments. It holds controlled substances and drug manufacturer and wholesaler licenses from the Michigan Board of Pharmacy and federal Drug Enforcement Administration, as well as a drug establishment registration from the Department of Health and Human Services.

The organization sends its supplies through 40 licensed relief agencies to clinics around the world. Shipments go to missions or disaster areas only, and only to licensed clinics or hospitals. Prescription medicines are shipped only to places having a qualified physician on the staff.

All shipments are used for the care of the destitute and sick only, and go only to developing countries. Most shipments go to missionaries of any faith and are cleared before the shipment leaves the Detroit warehouse that they will be received into the country and by the consignee duty-free.

Mrs. Auberlin in a corner of her pharmacy.

Immediately after accepting her MSMS award, Mrs. Auberlin plunged into gathering, crating and shipping two 40-foot land-sea container cars full of medical supplies to Poland. The containers together held almost 72,000 pounds of supplies valued at almost $4 million.

"We don't leave space for a mouse in our containers," she boasts. "If there's any room left over, we stuff it with disposable diapers and peri-pads."

"Where," asked Muriel Tisdel during our warehouse tour, "are they going to get 100 people to replace you someday?" In addition to coordinating the global efforts of World Medical Relief, you see, Mrs. Auberlin handles promotion for WMR, writes a newsletter, maintains a busy speaking schedule. She meets with individuals, foundation representatives and others to apply her brand of "pressure begging" on behalf of her organization. She even whips up special baked treats for her "brown-bagging" volunteers.

"We've been looking for someone to replace me," replied Mrs. Auberlin, a show of uncertainty crossing her face for the first time. "We need someone who doesn't have to be paid. No one has turned up yet; I guess that's why the Good Lord let me feel so good so long."

She boasts she never even has a headache. Her doctor complains he never sees her, and came to the warehouse recently to take her blood pressure.

"I absorb all the medicine I need just by walking by it in the warehouse," she says with a grin.

She's up at 6:15 a.m. every day, works up to 12 hours a day. "There's so dang much to do around here."

"I believe God got me into this, because I had no background," she continued, "I feel but for the grace of God it could be me needing help. Many of these old people never had to ask for any help in their lives.

"Many of their doctors don't even know," she said, patting Doctor Tisdel on the arm for emphasis.

Physicians wishing to donate medical supplies to World Medical Relief may write the organization at:

World Medical Relief, Inc.
11745 Twelfth Street
Detroit, MI 48206

WMR needs medications

The Niger Republic Clinic of Michigan doctor James Ceton, MD. Doctor Ceton is one of the missionary physicians aided by World Medical Relief.

Here's how you can help!

Mrs. Auberlin tells of World Medical Relief's needs in her own words in the following passages taken from a recent letter to MSMS President James H. Tisdel, MD, Port Huron.

"Our greatest need, of course, is medication, because we beg and we give — with one exception. I have been forced to solicit funds to purchase medication for the local program, as some pharmaceutical houses do not seem to be receptive to giving for our local program but will contribute for overseas missions. But with the thousands that are being dropped from Medicaid and are coming to us we are going to need some help to obtain these drugs gratis.

Difficult drugs

Below is a list of the drugs we are having problems in obtaining for our local program. Any help you could give us in this area would be a godsend:

Aldomet 250 mg Tabs
Aldomet 500 mg Tabs
Dyazide Caps
Diabinese 250 mg Tabs
Diabinese 100 mg Tabs
Insulin (preferably Lente U100) is an urgent need.
Lanoxin 0.125 mg Tabs
Lanoxin 0.25 mg Tabs
Nitroglycerin 2.5 mg Caps
Nitroglycerin 6.5 mg Caps
Persantine 25 mg & 75 mg Tabs OR Generic Rugby's Dipyridamole 25 mg
Pavabid 150 mg Caps OR Rugby's Pavagen 150 mg
Quinidex Extentabs 300 mg
Minipress 5 mg Caps
Renese-R Tabs
Slow-K 600 mg Tabs
Tagamet 300 mg Tabs & 200 mg Tabs
Zyloprim 100 mg Tabs & 300 mg Tabs

Your physician membership can be of tremendous help in this area by making a personal contact with the detail men of the various pharmaceutical houses that call on them and making a plea for our needs.

"I am sure that many of the physicians would have great influence with some of these pharmaceutical houses, or the hospitals on whose staff they serve, in convincing them of your involvement with us to be more generous than they have been in their donations of drugs to us.

"We are at least three years backlogged in filling requests. Our program is growing by leaps and bounds and of course all they give is tax deductible.

"I am sure we are the only agency of its kind that handles drugs that has always had a pharmacist. At the present time *we have two registered pharmacists on a five day schedule and two volunteer pharmacists giving us one day a week. We have all the licenses needed to operate* a drug program.

"Another great need we have with so many doctors going into the mission field is for surgical instruments. Many of your physician membership have instrument cabinets loaded with surgical instruments which they no longer use as they refer their patients to a hospital. We also desperately need microscopes and blood pressure apparatus. Please make an appeal for these. This could be nationwide.

"Another sinful waste we have uncovered and which your staff physicians at hospitals could be of great help in directing our way is that all ORs, due to the cost of labor, are throwing away practically tons of dressings, sutures and other supplies when probably only a few items from packs have been used. The rest are thrown away. We repackage them as unsterilized items, for which the missionaries are deeply grateful. They do their own sterilizing.

Medications needed

Here is a list of medication needs, by category, that we are running low on for our overseas program. *We never have enough antibiotics, anti-malarial* or *antiparasites medications*. These conditions all are prevalent in practically every country into which we ship.

Antibiotics
Diarrhea
Geriatric
Vitamins
Skin
Body Chemicals
Eye & Ear
Heart
Hypertension
Asthma
Ointment
Nose & Throat
Cough & Cold
Antihistamines
Analgesics
Rheumatism
Muscle Relaxant
Gastrointestinal
Antiemetic
Antibacterial
Injectables
Soap — medicated
Soap — liquid

"Whatever you do will have to be more than a one-time shot," admonishes Mrs. Auberlin, "as we have found out over the years that people will become enthused for a time, then their compassion and dedication will phase out."

But, she concluded to Doctor Tisdel, "the prestige that you will lend to our organization through your involvement is immeasurable . . . we are sincerely and humbly grateful that we have earned your confidence and concern."

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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REFER TO PDR

MSMS Annual Scientific Meeting to shed light on technologies' uses

Michigan physicians may plug in to the new technology of medical practice at the 1982 MSMS Annual Scientific Meeting. The three-day event is scheduled Nov. 9-10-11 at the Hyatt Regency Dearborn.

MSMS is actively promoting the conference now to allow physicians plenty of time to make their plans. They may choose from 55 half-day courses offering a total of 18 Category I CME hours.

Among the courses are several which provide insight into the uses and management of new machines for achieving and maintaining better health care. These courses and their directors include:

"Technology Explosion in Obstetrics/Gynecology," Donald R. Krohn, MD, Novi, and Ernest Hammel, PhD, Rochester. Sponsor is the Oakland Health Education Program.

"Management of Mechanical Ventilation," Morris Brown, MD, Detroit, sponsored by the Michigan Society of Anesthesiologists and Department of Anesthesiology, Wayne State University School of Medicine.

"The Advancing Technology Parade in Ophthalmology," Frederick W. Bryant, MD, sponsored by the Michigan Ophthalmological Society.

"Nuclear Cardiology: Uses in Clinical Practice," James H. Thrall, MD, Ann Arbor, sponsored by the Department of Nuclear Medicine, University of Michigan Medical School.

"Pediatric Ultrasound — How You Can Effectively Use It In Practice," Thomas L. Slovis, MD, Detroit, sponsored by the Michigan Radiology Society.

These new courses reflect the growing importance of machines to the modern physicians' healing armamentarium. Yet they remain tools, and must be carefully managed, their use kept in perspective, emphasizes Frank Cox, MD, Annual Scientific Meeting Director. (Doctor Cox is director of the Office of Continuing Medical Education at Henry Ford Hospital, Detroit.)

"There is a great deal of interest in learning about the new technologies, particularly on the part of the practitioners," observes Doctor Cox. "This is because of the tremendous advances made in recent years.

"It is difficult for individuals to keep pace with all the developments, so I feel they will perceive our courses as helpful. I believe they will see our courses as an opportunity to better understand the limitations, the applications and the uses of the new technologies, as much as the scientific basis for their development.

"It is important to learn when to ask that these technologies be employed in medical care."

Doctor Cox reveals there was no conscious effort on the part of the ASM Task Force to get more courses on technology included in the roster of courses.

"They came to us more as the result of a grassroots move from the various specialty societies to offer greater information to the practitioners. It is really more of a coincidence that we have several such courses offered this year."

This advance information will be followed in the September and October issues of *Michigan Medicine* and *Medigram* with detailed course listings and registration forms. MSMS members then will be able to learn the general description and purposes of each course, the names, professional positions and topics of each speaker and the names and backgrounds of each course director.

Most courses will be presented in the new poolside wing of the Hyatt Regency, in close proximity to the MSMS registration desk, exhibit hall and other courses. Many will be repeats of the well-attended offerings on diabetes, stroke, hypertension, chronic head and back pain of previous Annual Scientific Meetings.

Several others will discuss current concerns such as emergency psychiatry, ethical practice habits, workplace ailments, aiding the impaired physician, changing patient behavior, sports medicine and genetics.

Major Michigan specialty societies and the state's three medical schools all are sponsoring and arranging courses.

"We are looking forward to having another outstanding meeting," concludes Doctor Cox.

For further details, MSMS members may contact Sherry L. Fent at MSMS headquarters.

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MSMS committed to ensuring quality medical care

By Kirk McMurray
East Lansing

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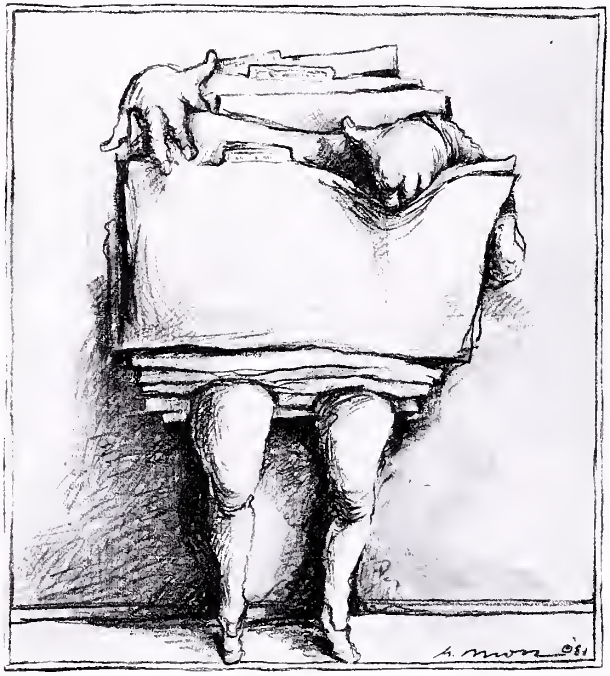

Peer review: the concept is familiar, the rationale understood.

Still, organized peer review remains a highly contestable issue. Though conceptually simple, it becomes a complex maze of considerations regarding physician rights and responsibilities when attempts are made to make the activity formal.

MSMS supports

The Michigan State Medical Society supports the concept of peer review. Stated policy affirms that of the AMA:

> Medical society ethics committees, hospital credentials and utilization committees, and other forms of peer review have been long established by organized medicine to scrutinize physicians' professional conduct. At least to some extent, each of these types of peer review can be said to impinge upon the absolute professional freedom of physicians. They are, nonetheless, recognized and accepted. They are necessary. They balance the physician's right to exercise his (or her) medical judgment freely with his (or her) obligation to do so wisely and temperately.

Mr. McMurray is an intern with the MSMS departments of communications and socio-economics. His field is marketing.

In the early 1970s MSMS thoroughly explored the possibility of forming a foundation for medical care in the state. Articles of incorporation and bylaws for such an organization were drawn up and approved by the House of Delegates. This was before the passage of federal professional standards review organization (PSRO) legislation in 1972 captivated the attention of Michigan physicians and diminished their perceived need for an independent review mechanism.

The PSRO amendment to the Social Security Act mandated the creation of a national network of physician-run peer review organizations. Affecting only the Medicare program in Michigan, the PSROs were charged with assessment of utilization and quality of care rendered. They had final authority to grant or deny payment, were federally funded, and functioned under the auspices of the federal government.

The economic climate of the 1980s and the federal government's strained budgets convinced the Reagan administration that continued funding of the PSROs was not practicable. A gradual defunding process hence has begun and should be completed within the next several years, terminating many of the PSROs.

MSMS members, however, remain committed to ensuring the delivery of quality medical care — care which is necessary and represents the effective utilization of resources. And they believe peer review remains the best means for achieving these ends. Only physicians possess the medical knowledge and breadth of experience needed to appropriately judge the quality of their colleagues' work.

Council acts

In a reaffirmation of the basic soundness of the concept and of the importance of self regulation by the profession, the MSMS Council acted in December 1981 to develop a task force responsible for exploring the possibility of MSMS peer review involvement. In this way, the councilors reasoned, the profession can fulfill its obligation to determine what is medically necessary and appropriate and also can guarantee that medical care decisions are made on qualitative, not financial, bases. Should the profession forfeit this opportunity, other parties, such as patients' employers, who may not view quality of care as the primary concern in medical care delivery, may make appropriateness decisions according to their own criteria.

Since the Council's December action, the House of Delegates has approved the formation of a "statewide organization to promote, market, monitor, and provide a state level appellate mechanism for peer review."

Continued on page 438

FINANCIAL INFORMATION

NAME____________________ HOME PHONE______________ OFFICE PHONE______________

	DESCRIPTION	SELF	JOINT	SPOUSE
REAL ESTATE	RESIDENCE	$	$	$
	OTHER			
LIFE INS.	GROUP			
	PERSONAL			
EMPLOYEE BENEFITS	PENSION			
	PROFIT SHARING			
	OTHER			
STOCKS	MARKETABLE			
	CLOSELY HELD			
	BANK ACCOUNTS			
	BONDS			
	PARTNERSHIPS			
	PROPRIETORSHIPS			
TANGIBLE PERSONAL PROPERTY	FURNISHINGS			
	AUTOS, ETC.			
SUBTRACT ALL LIABILITIES				
TOTAL NET WORTH		$	$	$

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Entitled "Physician's Review Organization of Michigan (PROM)," this MSMS subsidiary will provide centrally administered *local* peer review for quality assurance under MSMS sponsorship.

Local review

Local review will be achieved by maintaining the PSRO geographic divisions wherever possible in order to preserve their existing databases and use their available expertise. This will be accomplished by contracting with the local organization to perform the actual reviews.

Complying with PROM policies and guidelines, these organizations will provide information concerning the physical or psychological condition of patients whose cases are reviewed, and will determine the necessity, appropriateness, and quality of health care rendered them. Directives or judgments concerning the level or propriety of fees shall not be made.

All data generated and recommendations made by the regional contractors will be confidentially reported to PROM, which will remain responsible for forwarding the information to those insurers, hospitals, corporations, government agencies, and individuals who have contracted with PROM for the purchase of peer review services. The information also may be sent, when required by law, to those entities which license or regulate health care providers.

In either instance, however, subsequent disciplinary actions arising from the review data are to be handled exclusively by the parties receiving the information — not by PROM or by any of its contractor reviewing affiliates.

PROM will function as a review entity in accordance with the Michigan Peer Review Immunity Statute (MCLA 331.531-331.533). Under this statute review information may only be released in the following instances: to advance health care research and education, to maintain the standards of the health care professions, to promote the delivery of quality health care consistent with considerations of cost, and to protect the financial integrity of any governmentally funded programs.

Peer review, as performed by the Physician's Review Organization of Michigan, will be more broadly based than is hospital specific review. This is appropriate and important for effective qualitative evaluation. And the fact that PROM can provide a means of reviewing ambulatory services may induce third party payors to increase reimbursement for these procedures.

The medical profession will further benefit from PROM's peer review activity in that the review information can be amalgamated into a state-wide database. This resource can be used to highlight specific problems so that well-focused solutions can be developed as MSMS determines health policies.

Physicians affiliated with PROM's regional review contractors and those individuals involved in PROM as corporate officers or directors shall be given the broadest indemnification possible for all legitimate activities undertaken on behalf of the corporation.

Structurally, as stipulated by the House of Delegates, PROM will be a wholly-owned MSMS corporate subsidiary. Designed as a non-profit organization, it will qualify for tax-free status under the Internal Revenue Code.

Board's responsibility

Responsibility for managing the affairs of the organization will lie with a board of directors elected by the MSMS Council. A preliminary proposal for the PROM Board consists of a minimum of 21 members serving staggered three year terms. Ten of the Directors are to be members of either MSMS or the Michigan Association of Osteopathic Physicians and Surgeons and must be past or present members of other peer review organizations. The 11 remaining directorships are to be filled by six physician members-at-large, two MAOPS members nominated by the MAOPS Council, two MSMS Council-nominated non-physician members, and one MHA-nominated hospital representative.

Organizationally, PROM is unique. Its service will be as well. Compared to the PSRO's federally funded concurrent review, PROM's private review is more flexible in its approaches and can appeal to more potential service purchasers.

As expected, our legal right to do selective editing was challenged. In an administrative hearings decision, the department stated that the selective editing process was not unreasonable. However, on June 11, a preliminary injunction was issued by an Oakland County Circuit Court judge on behalf of four physicians. We were required to immediately remove these four physicians from selective editing and pay them for all such claims being held and evaluated in the system pending what will likely be a lengthy court review of the merits of our selective editing activity.

It is our intent to maintain the selective edit process. However, placing any of those physicians removed from selective editing, or others, back on this review will be a lengthy process. Each must be taken through a bureau conference and likely an administrative hearing to establish probable cause for overutilization based upon medical records.

It is apparent, however, that other controls must be implemented in this area. A second course of action came under consideration as a result of our mutual recognition of the lengthy and complex processes related to retrospectively identifying and controlling overutilizing providers. This course of action suggests some type of cap or limit on the number of tests and dollars for which we would reasonably pay for any one patient/episode/diagnosis. We have been reviewing the practicalities of such an overall approach and are now developing a process to install a prior authorization threshold. . . .

Unfortunately, we will continue to pay many hundreds of thousands of dollars for unnecessary laboratory services until we place back on selective editing those physicians we are forced to remove and institute the cap and prior authorization exception process. I know that you are as angry and as frustrated as I am with the obstacles encountered in efforts to effectively control these abusive practices.

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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Please see summary of product information on following page.

References: **1.** Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Kales A *et al*: *JAMA 241*:1692-1695, Apr 20, 1979. **4.** Kales A *et al*: *J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **6.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al*: *Behav Med 5*(10):25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **14.** Kales A, Kales JD: *Pharmacol Physicians 4*(9):1-6, Sep 1970. **15.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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Michigan's Space Shuttle pilot suffered motion sickness

By Willah Weddon
Stockbridge

It's been called seasickness, motion sickness, canal sickness, motion sensitivity and now space motion sickness.

It's plagued man from the time he ventured from terra firma to travel on the sea. Despite fantastic scientific progress, the symptoms of motion sickness still afflict about half of all astronauts. And the new space age version includes the additional problem of weightlessness.

Michigan's space shuttle Commander Jack R. Lousma was no exception on the third flight of Columbia, during the last week in March. He described his symptoms and treatment for readers of *Michigan Medicine* in an interview recently in Lansing.

"For the first two days we didn't feel very well. We felt nauseous to some degree. But it was hardly the problem on board that it seemed to be in the newspapers on the ground," he recalled, grinning.

"It was not necessarily motion sickness, althought it felt that way. Certainly there's some sort of a disparity betwixt what the inner ear is sensing and the eye is seeing."

"It's something you just have to get through. It's more of a nuisance," he continued. "When it was over we put on the feedbag and were back to normal."

Mission Pilot C. Gordon Fullerton, Lousma's flying partner, said after he'd eat there was a fullness, a feeling of fluid that built up, so he didn't eat and began to dehydrate. "Then he forced himself to eat and felt better," said Jenny Barnes, the astronaut's scheduling aide, who was traveling with Lousma.

"It's very unpredictable as to who is going to get sick. You can be one of the most resistant on the ground, but one of the most sensitive while in flight and vice versa," Lousma explained. "In fact, our Skylab crew members (Lousma's Skylab space station in which he spend 59 days in orbit in 1973) was the least sensitive group on the ground but were the most affected by nausea when we got up there."

Special Medicine

In an effort to desensitize themselves, the two astronauts each spent some time prior to the third flight of the Columbia, flying aerobatics in their individual T-38 trainers. This may have helped reduce their motion sickness but did not prevent it.

"But it only lasted a couple days and we do have some medications for it," Lousma said.

What medication?

"It's a combination between scopolamine and dexedrine (dextroamphetamine sulfate). The scopolamine reduces the symptoms and the dexedrine keeps you from being put down or made drowsy by the scopolamine," he explained. "I don't think it's a medication available commercially. It's made by our labs at NASA, but it's very effective in combating motion sickness.

"I've used it at sea and other places, where it's also effective," he said. "It will be a good thing to get on the market, eventually."

The use of biofeedback was not tried aboard the Columbia, Lousma said. This method, with trained subjects monitoring bodily functions and learning to recognize when their bodies are operating best, has been shown in tests to be about 65 percent effective in improving the ability to suppress motion sickness. Patricia Cowings, PhD, psychophysiologist at NASA's Ames Research Center, has been developing this theory. It may be tested in space on one of the life science missions abroad a Space Shuttle in 1983 or 1985.

In addition to space motion sickness, researchers are trying to understand physiological changes which have been observed in man during spaceflight. Among these are loss of bone calcium, deconditioning of the cardiovascular system and shifts in fluid and electrolyte balance. These studies will establish medical criteria for passenger scientists aboard future Space Shuttle missions.

Scientists also are looking for ways to speed the detection and identification of disease, to determine drug effects in space, to develop biochemical and hormonal predictors of stress tolerance limits

Continued on page 444

Ms. Weddon is a Lansing area freelance writer.

How it feels to fly in space

Commander Lousma

Born in Grand Rapids and raised in Michigan, Lousma has been involved in the space program for 16 years. During his most recent space flight he completed 130 revolutions of the earth and traveled some 3.4 million miles.

While being honored recently in the Michigan Senate chambers, and as a guest of Senator Robert VanderLaan (R-Grand Rapids), the Commander told of some of his thoughts and impressions:

Feelings before liftoff

"When we rode out to the launch pad I asked my partner to come around and take one more look at the side of this vehicle. We walked away from the launch pad so we could see the whole thing. It can intimidate you, it can overpower you. It's awe inspiring. And to feel you're going to be the one in this thing, controlling it, can be an overwhelming experience if you allow it to be.

"Somehow I had to desensitize myself to this fact and realize I was going to fly this thing. It was something I'd wanted to do for many years. I was trained to do it, it was important to do and I was going to do it . . . irrespective of what my personal feelings might be . . . even if I had to grit my teeth.

"We went up the elevator and walked across the swing arm to the cockpit with that feeling in mind. Once in the cockpit, of course, we felt at home. We'd trained in a simulator that looked just like this one, for thousands of hours.

"Of course your thoughts are filled with what to do next if things go normally and what to do if things go wrong. So there really isn't what you could call a feeling of fear. I think fear is caused by absence of knowledge and we certainly had had every opportunity to learn and train.

"While you're waiting for liftoff, your thoughts do contain questions like 'What am I doing here?' But there's nothing you can do about it. So you just lean back and decide to pull off a successful mission.

"At the moment of liftoff, when counting down from 10, I reached over and wished my buddy good luck and, of course, he returned the good luck.

The liftoff

"At the moment of blastoff you can feel the engines ignite. You can't hear all the noise that's heard on the ground, but you can sense it through the vibrations . . . you can feel the engines crank up speed, watch the response in the cockpit and have confidence it's working properly.

When the big bird got off the ground there was a lot of vibration, a lot of power, a demonstration of dynamic activity. We felt like we had a lot of tigers in our tank down there. We could feel those engines throbbing and vibrating and pushing us on up to orbit. There was just a relentless, forceful, continuous push and acceleration all the way for eight and one-half minutes to 150 miles.

When we were orbiting, we circled the globe every 90 minutes — about 60 minutes in daylight, 30 minutes in darkness. There are 16 sunrises and sunsets every day, so you get to see a lot of them in a hurry. It is high adventure all the way."

Unusual aspects

"We lost a few tiles, in non-critical areas . . . that was an unusual occurrence.

"We floated for eight days. To be perfectly weightless is one of the remarkable aspects of space flight and very difficult to explain to those who haven't done it. A very comfortable, relaxing feeling.

"The sky is always black in space, never blue. Even in the daytime the sky is black . . . the world below is beautifully lit and the sky is black.

"The sunrises and sunsets are unusual and unique, because they happen so rapidly. The sunrise comes up like an atomic explosion on the horizon. When the sun goes down, it's totally dark immediately.

"I recall in my Skylab flight when I was doing a space walk, changing the film in a camera out there on the end of a telescope. I was hanging on by one foot and all of a sudden the sun went down and we didn't have the lights on. Here I was, whirling around the world 18,000 miles an hour, hanging on by one foot and I couldn't see my hand. Now that's an unusual experience."

Philosophy

"We worry too much about small things that really don't matter. I think this is one of the lessons that has been driven home to me while flying in space. We ought to remember there is a bigger world out there, a bigger universe, and we shouldn't be so embroiled in the trivia we get involved in.

"We noted we could see the world the way God made it and we couldn't see the people-made boundaries dividing countries and even states. Someday the whole human race will, I hope, view itself without boundaries.

"We were whirling around the

Physician Maldistribution topic Sept. 9-10

A conference to study ways to improve the distribution of physicians throughout the United States will be sponsored Sept. 9-10 by The University of Michigan School of Public Health.

Participants in the National Meeting on Physician Maldistribution will include state and local government officials, medical educators and private organizations. The meeting is being organized by the Physician Distribution Incentive Project (PDIP) at the U-M school under a grant from the W. K. Kellogg Foundation.

Workshops will involve an examination of strategies to improve physician distribution and to increase care for the medically underserved. The results of a brainstorming session to implement these strategies will be published after the meeting and made available to all participants.

The Physician Distribution Incentive Project has recently compiled a "National Compendium of Non-Federal Physician Distribution Programs." The Compendium identifies 150 state and local programs throughout the country that address physician maldistribution. Findings from that study will be shared with participants at the conference. Limited copies of the Compendium are available from the PDIP.

Additional information concerning the National Meeting on Physician Maldistribution may be obtained from the Department of Conferences and Institutes, U-M Extension Service, 412 Maynard Street, Ann Arbor, 48109.

LOUSMA/*Continued*

world at five miles per second, eight times faster than a speeding bullet in the most sophisticated machine that ever has been built. On the other hand we were looking down on land where people have never had a square meal or don't have medical attention . . . places where people are still fighting all around the world.

"We all are privileged to live in this United States of America but we have to be sensitive to the rest of the people around the world on a continuing basis.

"There are some analogies between our spacecraft Earth and the spacecraft we were on. Resources on both are limited. If the crew doesn't get along, it won't be a successful mission. If we don't get along better with one another on our spacecraft Earth, our voyage isn't going to be nearly as successful or safe as we'd like to have it."

Re-entry

"We entered the atmosphere in the darkness and when we did, we started to develop an orange-pinkish glow outside the window. The molecules were being excited and giving off light. This was the shield that comes around the spacecraft and causes the blackout in communications, and we were actually able to see it. It got brighter and brighter and actually lit up the windows in the whole cockpit, just like a fluorescent lamp. Then we burst into sunlight and all that went away. But it was a spectacular show that hasn't been seen much before.

"This big machine had a relentless slow down, a feeling for about 20-30 minutes of the spacecraft digging it's heels in, as we decelerated from 25 times the speed of sound until the wheels touched down and stopped on the runway at White Sands Missile Base."

SPACE/*Continued*

and to mitigate psychological problems that might occur in humans during flights of long duration.

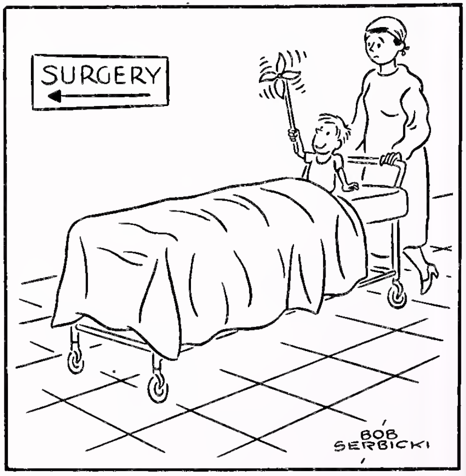
Michigan involvement

Now in the Shuttle era, NASA plans to make space-flight available to the broadest possible segment of the scientific community. Lousma pointed out that Michigan universities and colleges do some work with NASA, but only one-half the amount this year as they did in 1981. He urged greater participation.

"We have the research facilities and the minds to put to it, so I want to encourage you to get more involved," he said. "There is a good deal of work to be done out there."

Although the University of Michigan's aerospace engineering department has had a continuing working relationship with Lousma throughout his career as an astronaut, the medical department appears not to have kept pace. A search by the Script office in the University's Division of Research Development and Administration revealed only five faculty members presently interested in space medicine research.

Several University of Michigan alumni have, however, been involved directly in the space program. These include astronauts James A. McDivitt, Alfred M. Worden, Alan L. Bean and Brewster Shaw, who is going to be flying on the ninth flight of the Space Shuttle, as well as Lousma. Others, such as Robert F. Freitag, deputy director of advanced programs for NASA, have worked behind the scenes to make their flights possible.



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Where do doctors come from?

The first decade of a successful premed program

By J. Michael Coyne, MD
Jacob Vinocur, PhD
Marquette

"There are just not enough doc's up in rural areas."

Sound familiar? Well, several years ago the Marquette-Alger County Medical Society and Northern Michigan University developed an innovative way to deal with this problem.

This unique effort has been successful in increasing the number of rural students entering medical school and staying there. We hope it will result over the next few years, in many of these students returning to the Upper Peninsula to practice.

This joint effort is beginning to earn an outstanding reputation for preparing young men and women for careers in medicine.

It was not always thus. In the first 30 years of the existence of the university, only one student went on to medical school. In the years when entrance to medical school was chiefly a matter of interest, there was apparently little among Northern's students. Thus, in the 1930's, only about six persons went from Northern into medical school (records are almost non-existent); in the 1940s, two; in the 1950's, about nine. In the 1960's, however, interest awakened, and about 20 Northern graduates were admitted to osteopathic and allopathic schools, almost all of them in Michigan.

In the early 1970's, two sets of circumstances emerged. First, interest in medicine as a career surged, not only locally but nationally. Northern, like many other schools, found itself with a small number of highly motivated students genuinely interested in careers in medicine. Second, the medical schools found themselves inundated by large numbers of students seeking admission, and at the state schools there was increasing pressure to limit enrollment to citizens of the states whose legislature paid the bill.

As these academic and political pressures increased, and as the severe shortage of physicians in the Upper Peninsula and other rural areas became increasingly evident, the Medical Society and interested faculty at Northern developed an innovative plan to assist qualified students in entering medical school. They also hoped to encourage them to return to the Upper Peninsula to practice.

Over the past 10 years, these faculty members and local physicians have developed programs to make the achievement of these ends possible.

The basis of the premedical and program has been the Premedical Advisory Board, which is composed of three faculty members from Northern Michigan University and six community physicians. The interest, experience, and participation of this Board is in many ways the key to the success of our programs, for the board affords knowledge and judgment not only about undergraduate preparation, but also about professional training and experience. In a word, the board is a rich resource for our students and our programs, giving to both a direction and breadth they would otherwise lack.

Education

With the aid and advice of the board, each of Northern's premed students undertakes four complex and protracted tasks. The first of these is his education. All universities pay lip service to this ideal. The boiler plate of college catalogues is filled with references to "educating the Whole Man" and "transmitting the culture of the West" to each incoming freshman. It is a tradition most often honored in the breach. Premeds normally expend much more energy on calculus and chemistry than on history or literature or philosophy or any other intellectual discipline which will help them to become more humane and sharpen their perception of things. For whatever reasons, students appear to leave high school with very little real education and even less development of their verbal skills.

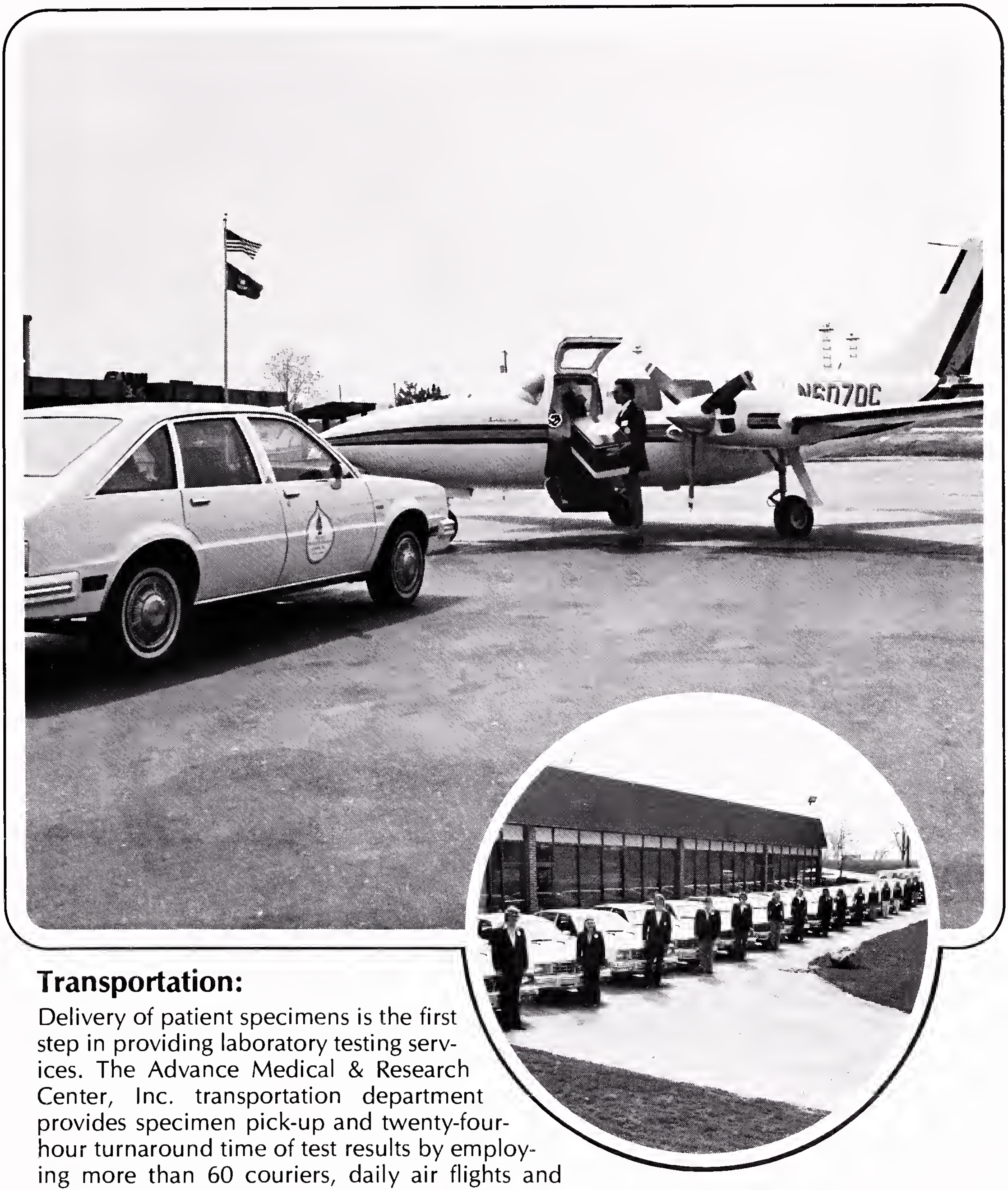
Northern tries to deal with this problem in two ways. In the formal structure, premed advisors, all of whom are members of the PMAB, share the view that students need as broad an education as possible. Students are placed in the most rigorous courses available in the humanities and social sciences. A special composition course has been designed for them. The philosophy department gives a course in medical ethics which many students report to be one of the most stimulating and thought-provoking courses they have taken in college. The habit of reading for both information and pleasure is encouraged. To this end, with the assistance of both faculty members and the PMAB, a book list has been designed to engage the students' interests, broaden the range of their information, and cultivate the habit of systematic reading.

Training

While everything possible is done to assist the education of our students, the goal also is to provide them with excellent training. Northern has no special "premedical" curriculum. Rather, our faculty and board have chosen to require that our students take standard departmental majors such as biochemistry, chemis-

Continued on page 448

Doctor Coyne is president of the Marquette-Alger County Medical Society, director of rehabilitation medicine at Marquette General Hospital and a member of the Premedical Advisory Board. Doctor Vinocur is chairman of the board, honorary member of the Marquette-Alger County Medical Society and professor of English at Northern Michigan University.



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try, and biology. The board believes that such study affords excellent preparation for the MCAT (especially when the student has been well advised), and at the same time provides him with viable alternatives in case he changes his mind about medical school or fails to gain admission. On the basis of performance on MCATS, grade points earned and reports from students who have gone on to medical schools, we know that our students have the technical foundation to do well in their professional training. Many of them have told us that the people from Northern are as well prepared as anyone in their classes at med school, and many of our students in medical school have been exempted from biochemistry courses and genetics on the basis of exams given by the medical schools.

Medical world

But the PMAB feels that excellent education and training are not in themselves adequate preparation for a career in medicine. A fully adequate preparation must include some real appreciation of the demands made by medical school and the careers which follow. We have discovered that while it is extremely difficult to give students any realistic sense of the profession, it is not impossible. Students are encouraged and assisted in taking on volunteer work and summer jobs in Marquette or their home town hospitals. In addition, the Premed Society brings to the campus physicians from the community and other persons from the health field (e.g., specialists in nuclear medicine and physician's assistants), who discuss with our students their professional roles and obligations. And thanks to the cordial relationship of the PMAB and the local medical community with our students, many premeds are guests at the physicians' weekly clinical conference held following lunch in the hospital. There our students become acquainted with physicians and hear them describe their own professional tasks. This privilege is cherished by the premeds, who find it is one of the best ways for them to gain a real sense of the world of professional medicine.

Experimental seminar

One development of this rather informal introduction to the practice of medicine deserves special remark. It is an experimental undergraduate seminar for a selected group of premeds. It is a one-credit course that meets bi-weekly in the evening. The Board choose the topics, arranges them, and assists in the selection of physicians to conduct the seminars. Topics range from the relatively simple "how-to" of MCAT, application and admissions procedures, through reports on "Medical School Today" (conducted by one of our own graduates who is currently a third-year student in a major medical school), to a discussion of "Medical Care: Right or Privilege." Reading selections are made by the physicians concerned. The seminars provide young students with excellent role models from among practicing physicians and with a new sense of the context within which medicine is actually practiced: it acquaints them with the broad range of social, ethical, political, and economic dimensions within which they will practice medicine. It gives them a solid look at the prospect before them. And finally, it provides our students — as many of them report to us — with the best possible preparation for the interviews conducted by the medical schools.

Board interview

The Board undertakes one more obligation. It interviews, assesses, and recommends those candidates for medical school who wish to avail themselves of this privilege. Once a student has taken the MCAT and assembled his letters of recommendation, he may apply for a board interview. On the basis of this interview, lasting from an hour to an hour and a half, the Board makes an evaluation of the student. The ranks are superior, *very good, good, poor*, and *do not recommend*. A copy of the Board's evaluation and its reasons is attached to the credential file which is then sent to each of the schools to which the student applies. A copy of the board's evaluation is also furnished to the student.

Numbers admitted

In the decade in which the program has been in operation our admissions to medical schools are as follows:

1973 -	6	1978 -	10
1974 -	10	1979 -	10
1975 -	5	1980 -	13
1976 -	11	1981 -	7
1977 -	7	1982 -	9
		Total	88

In addition, we believe this program is successful because a high *percentage* of our applicants succeed in gaining admission to medical school. In 1980, for example, 100 percent of our candidates were admitted; in 1981, 100 percent were admitted; and for the fall of 1982, 9 out of 10 candidates have been admitted — and the final candidate is an alternate who may yet win admission.

These students have been admitted to schools ranging from the University of Colorado to the Uniformed Services University School of Medicine in Bethesda, and to both state and private schools. Moreover, many of them have won multiple admissions, some to as many as *five* medical schools.

Location chosen

It is still too early to know with great accuracy where our students will elect to practice medicine since so many of them are still in training. We do know that they are entering specialties ranging from family practice to neurosurgery, and we do have some returnees. And many of our students have indicated a desire to return to practice in the Upper Peninsula. We intend to keep in close touch with these people and as their careers develop, we shall be able to report more fully on where they elect to practice. On the basis of current trends and discussions with our students, we are confident that many will return to this general area.

The program at Northern is highly successful because we have good students, good faculty, good academic programs, and interested and informed assistance from the medical community. We believe that our students are well prepared for the rigors of medical school and the practice of medicine, and that many of them will return to serve this isolated area.

Meeting the challenge of the 80's

In discussing patients' conditions, give most important information first

Physicians who have applied their own POP (poll of patients) test or have checked the more sophisticated polls of Gallup, Harris, et al, know that patients want to be consulted and advised.

They may not fully comprehend explanations, they may prefer to have the physician make all the decisions, but most of them want to hear it from the doctor in the plainest language. They want to know what's going on and why — in the examination process, in the treatment and surgical procedures.

For physicians and patients alike the purpose of their communication is not merely to convey information but to initiate certain action. It is not only the words used which are substantive, but every nuance of expression, smile, frown, gesture, tone of voice, show of emotion.

The physician is rarely the first or only person whose comments and demeanor have significant bearing upon the patient's understanding, acceptance and participation in the proceedings.

In the doctor's office, discussions with patients begin as soon as the patient walks up to the registration desk. First in the line of communication may be a volunteer, receptionist, aide, nurse or assistant, depending upon established office procedures, and who is on duty.

The patients may talk with one, all or a combination of intermediaries before the doctor comes on the scene. They can either add to or allay the patient's trepidation. But the tone of communication is often well established before the patient walks through the office door.

A person telephoning for an appointment is too often summarily made to understand that "we are loaded with patients today" and is left with the impression that the only time available is a week from some Tuesday.

Persistence will usually pay off for a determined patient who is willing to have a request for an examination turn into a cross-examination.

In the process the called may be subjected to personal questions that more appropriately should be asked by the physician, and have doubt cast on the necessity for even seeing the doctor.

When this patient shows up there's going to be trouble.

The first person on the office staff opening a dialogue will have to be a master at interpersonal relations. If not, the physician is going to be at a distinct disadvantage in establishing a meaningful discussion and diagnosis.

"The major defect of contemporary medical practice is precisely the failure of patient-physician communications. A diagnosis is impossible unless the patient's problem is communicated to the physician," writes William B. Buckingham, MD, associate professor of medicine at Northwestern University, in his forward to *Putting the Ill at Ease* by Evelyn Mayerson, EdD.

There is general agreement that the better the communication among physician, staff, and patient, the more effective the treatment. Timely, unfettered intraoffice communications, with full participation of the physician and office personnel at all levels, leads to staff harmony and patient confidence in the professional integrity of the physician and aides.

The physician sets the modus operandi and the persona exemplar for the office staff in its relation to patients.

This article is a sample of selections on communications being prepared for the MSMS members' manual, "Meeting the Challenge of the 80s." The manual is the project of the MSMS Committee on Public Service, chaired by Robert D. Burton, MD, Grand Rapids. Excerpts will appear in Michigan Medicine *throughout 1982. They are designed to be removed and saved for reference.*

Following are examples of how physicians are affecting patient attitudes and staff effectiveness through open, free-flowing discussions with patients and concerned relatives.

These are real experiences of real doctors and patients. In the words of one of the patients, "I hope many of the doctors reading about my experience will recognize themselves; those who don't, I hope will be encouraged to go and do likewise."

Patient A

"I was referred by my personal physician to an ophthalmologist affiliated with a major university, an older man with teaching responsibilities as well as many patients.

"I was very apprehensive as I waited in a large room, with about a dozen other people. You can imagine my surprise when the doctor came to the door, asked the receptionist to identify me, walked over to my chair and introduced himself.

"We walked together into the examination room, with my confidence soaring."

Patient B

"From our first contact with Doctor X we were confident that we would be partners in dealing with my traumatic health problem. Right from the start he talked with us and treated us as intelligent adults capable of sharing in the tough decisions which were going to have to be made.

"After the first examination, he asked us to sit with him. 'I want you to hear this,' he said, as he called our family doctor and discussed his diagnosis. He insisted we remain with him while he and his secretary made the necessary hospital arrangements.

"As it turned out, I had to undergo outpatient surgery to remove an enlarged mole. My husband and I waited anxiously for the pathological report. A few days later the doctor's office called and asked me to come in.

"When we arrived, there were two other patients ahead of us. I was afraid we might have a long wait. But it was only a few minutes before the doctor walked into the waiting room to greet us with encouraging words.

"Yes, there would have to be more surgery, but the test reports were favorable. We were still concerned but more relaxed as we awaited our turn.

"When we entered the examining room, he reached for a prescription pad and on it sketched for us the procedure he would be following in the next surgical step. He explained and interpreted the pathology findings, then handed us the complete lab report to read.

"I went into the hospital for final surgery with absolute confidence in the ability and integrity of Doctor X."

Patient C

"When I walked into the doctor's office the receptionist, who had never seen me before, greeted me as though I were expected, with, 'you must be Mr. Z'

"She had my referral folder in front of her and immediately assured me she would not ask for information my family doctor had already provided. How refreshing! She also said, 'We want you to know that Doctor Y will keep your doctor aware of your treatment and progress.'

"Only a couple of questions and then, before I had a chance to sit down and wait, the doctor's nurse came to the desk and was introduced to me by the receptionist. No first name, buddy-buddy informality, but friendly and gracious.

"As the nurse ushered me down to the examination room, she talked about why I was there and helped to ease my concern; obviously she had read my file. She asked a couple of meaningful but unobtrusive questions. She told me the doctor was ready to see me and would be with me in a few minutes.

"The nurse suggested my wife, who had accompanied me to the office, join me. 'Doctor Y likes to talk to both of you,' she said. That was OK with me and my wife came in just ahead of the doctor.

"He told us more about the information in my file than I had known. He also was aware of certain facts I had given the receptionist and nurse, and amazed me by asking no questions which had already been recorded in the file.

"As we talked it was obvious he was inviting discussion, not lecturing. We responded and the exchanges continued as he conducted the examination. It was all over in a few minutes. Thank God the prognosis was good.

"The experience in this doctor's office was a rare one for me. I've been in and out of a lot of them. I know the good news had something to do with my feeling of well-being, but the doctor and his staff really made the difference.

"As we left the office, the nurse said, 'If you have any problem with that, just call me at any time.' This never happened to me before. Usually it's more like, 'Don't call me — I'll call you."

Certain dos and don'ts relative to physician-patient communications are basic and long-standing; others reflect changing public attitudes and expectations.

The first four in the following list are from a Market Opinion Research report, commissioned by AMA in 1977. The public and physicians were polled — the percentage of "yes" answers in each group is indicated:

- Be totally frank with patients about their illness and medical costs (84 percent public, 68 percent physicians);
- Post your basic fees for each service (70 percent public, 55 percent physicians);
- Spend enough time with patients to help them understand their illnesses and the treatment needed (63 percent public, 66 percent physicians);
- Give patients an opportunity to share decisions on

Continued on page 452

Meeting the challenge of the 80's

Goal-setting may add perspective which makes physician competitive

The essence of personal planning is to know what you should be doing, how you should be doing it, and how long it should take. Success in any field is easier to accomplish if goals are set and methods established for reaching those goals.

In recent years much has been written about management by objectives (MBO), a theory formulated and articulated by George Odiorne, MBO requires statement of clear targets, then works out plans by which those goals may be achieved. The problem with MBO is that often too much time is spent in defining and planning the functions required to reach the targets — time which might have been used to perform the work.

Nothing ponderous

For those who do not have the luxury of a planning department that will help them develop a formal MBO program, all is not lost. It is possible to plan and set goals without estblishing a ponderous control mechanism to monitor and evaluate progress.

Many smaller organizations have used the technique of taking a group of leaders to a location away from all distractions where they proceed to develop mutually agreed upon goals. To be successful, the group must be committed to the concept of planning and must develop goals that are specific, attainable, and measurable. This requires that the functions of the organization be defined in a reasonably specific manner.

To cite an example related to medical practice, consider the planning required for appointment scheduling.

The first question to be asked is: Why is it necessary to schedule appointments? Some of the answers might be:

1) To reduce the amount of time persons must spend in the waiting room, thus allowing a reduction in size of the room;

2) To assure a steady flow of patients, assuming maximum productivity of the doctor;

3) So proper support staff can be on hand to assist the doctor.

Once it is agreed that scheduling is a desirable goal, some decisions must be made concerning the scheduling process. What system will be used? Who will be responsible for determining the length of time for each procedure? Which rooms will be used for which procedures? How will patients be notified? How are breaks scheduled? What about cancellations and no-shows?

In writing

It is imperative that goals be in writing, that they be specific about who is responsible, that deadlines be set, and that standards of performance be agreed upon. It may sound strange, but there are medical practices in which the question of profitability has never been discussed as a specific goal, only in an abstract sense. While they may have been acceptable in the days of high consumer demand and limited physician supply, it may prove disastrous in years to come.

Goal-setting carries with it the implication that some course of action will be taken if the goals are not met. Usually this course of action is discussed when the performance standards for reaching the goals are set. For example, a goal might set three levels of performance in connection with a particular objective: high range, standard, and low range. Since meeting goals usually entails the allocation of time and resources, both of which have monetary value, a recommendation might be made that staff additions or

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PRACTICE MANAGEMENT/*Continued*

cutbacks be options dependent on the level of achievement reached.

In addition to this goals statement, a budget would be established, not only for the position, but also for the expenses to be incurred in recruiting and training the person who is hired.

A physician in solo practice will consider such a mechanism useless and time-consuming, but even in this environment there is great value in setting organizational goals for and with your support staff.

Goal-setting also entails the setting of priorities to assist in decision-making when resources are not sufficient to meet all organizational objectives. It is important also to review each goal to determine if it fits the overall purposes and objectives of the organization. Certainly, goals and the purpose itself can be changed at any time, but the process should be a conscious one and not merely a matter of drifting away from the intended endpoint.

Great satisfaction

Most persons who use goal-setting in the management of their personal and professional lives find great satisfaction in reaching their goals. They also find the process useful in evaluating the circumstances that caused their failure to meet their goals.

A major benefit of goal-setting is that the process imposes a disciplined approach to organizational planning which gives the physician a new perspective of his or her practice. With this new perspective they will be able to understand and contend with the economic and societal pressures that will influence the practice of medicine in the coming years.

COMMUNICATIONS/*Continued*

treatment (*) (86 percent public, 91 percent physicians);

- Answer questions in terms and words patient can understand;
- Describe procedures with visual aids when possible — your own sketches or diagrams from published materials;
- Treat patients with dignity and respect (don't call patient by first name unless you wish to have patient call you by first name);
- Discuss diagnosis, clinical lab reports, treatment and prognosis candidly;
- Listen attentively to what your patient says or asks and comment or respond as precisely as possible;
- Assume your patient is as knowledgable on most subjects (other than medicine) as you are;
- Give the patient answers to the following questions as soon as possible during the diagnosis-treatment procedures — what's wrong?, what's the cause?, what should be done?, what will it cost?, how long will it take?
- Employ personnel who not only are efficient in their work but who also have personality traits which enhance good relations with patients.

In *Communicating with the Patient,* Philip P. Ley, MD, cites studies which establish that patients remember best (a) what they are told first, (b) what they consider most important, and (c) what they write down. He suggests that in discussions with patients, physicians

- give most important information first;
- emphasize the facts or instructions you consider most important;
- encourage patient to take notes.

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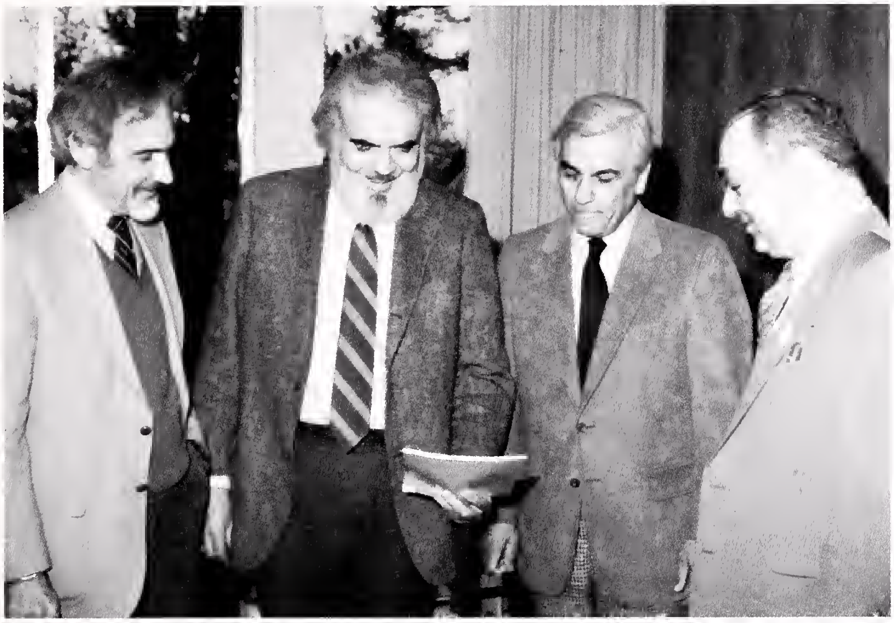
*Alfred Soffer, MD, disagrees with this advice. In "Consumer's Rights in Medicine," *Archives of Internal Medicine,* June 1978, he writes: "No amount of consumer education can substitute for reliance on the physician . . . We must be alert to dangers of programs which obscure the distinction between healer and sufferer."



A unique private sector effort to plan for the states' future graduate medical education needs is the Michigan Council on Graduate Medical Education. The Council formed March 16 at MSMS headquarters and elected the officers at left. From left, they are Gerson Cooper, Farmington Hills, MCGME treasurer; W. Donald Weston, MD, East Lansing, president; Carl A. Gagliardi, MD, Dearborn, vice president and MSMS representative to MCGME, and Philip Adler, DO, Farmington, secretary. MCGME currently is compiling accurate data on Michigan medical and osteopathic residencies.

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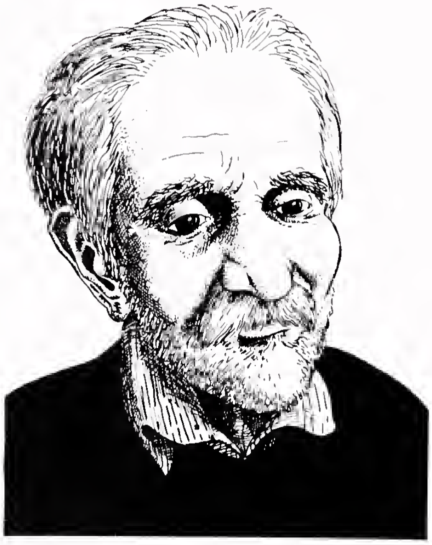
Here are new guidelines for health care of the elderly

By Russell E. Holmes, MD
Lansing



Physician support for and participation in screening, health maintenance and counseling programs for the elderly are needed to make these programs effective. New guidelines developed by the Michigan Department of Public Health will help ensure the effort is successful.

Background

Area Agencies on Aging, authorized under the Older Americans Act of 1965, have for a number of years made funds available to Michigan communities for preventive health screening services for the elderly. The mix of services provided has varied widely from community to community, suggesting a lack of consensus among providers of screening services to the elderly as to what health maintenance measures for older persons are appropriate.

The Michigan Office of Services to the Aging (OSA) in 1979 requested assistance from the Michigan Department of Public Health (MDPH) in developing guidelines for OSA-supported programs that provide health screening services for older adults, age 60 and over.

A committee of public health physicians, nurses, dietitians and health educators was convened by the Michigan Health Officers Association (MHOA) at the request of the Michigan Department of Public Health to review the scientific and professional literature and to develop recommendations for appropriate health screening measure for the elderly.

Recommendations

As a result of committee efforts, the following guidelines were developed, specific to persons age 60 years and over:

1. A recommended list of screening procedures and suggested indications for administration.
2. A self-administered medical history questionnaire.
3. A set of general policies for screening, referral, followup and evaluation, as follows:

a. There should be an awareness by health care providers of important demographic features and any unusual characteristics, risk status or special problems of the population served.

b. There should be mutually supportive, cooperative relationships among the local screening organization, the local medical community, and the organizations serving the aging.

c. The screening organization should have a permanent administrative structure to carry out a complete protocol including active referral, followup, data collection, analysis, program planning and evaluation.

d. Appropriate medical and nursing supervision should be provided.

e. At a minimum, an experienced, trained registered nurse should review the individual screening results and health history with each client and offer appropriate counseling, including interpretation of screening results, explanation of the difference between screening procedures and diagnostic evaluation, and medical referrals as indicated.

f. Nutrition and health education professional personnel also should be available to accept referrals of those screened, individually or in groups, for education and counseling in health promotion and/or for specific health problems.

Coordination

The success of community preventive health screening services directed to senior citizens will be substantially influenced by the degree of cooperation between the public health screening agency and the medical community. It is apparent that the age groups at the extreme ends of the lifespan have disproportionately greater health care needs. Some of these needs can best be met by private medical care, others by preventive, restorative or counseling services made available through publicly organized programs, in concert with private practitioners.

The Committee on Aging of the Michigan State Medical Society (MSMS), formed in 1981 in recognition of the special health problems of the growing numbers of older citizens, has reviewed the recommendations produced by the MHOA Committee on Health Screening of the Elderly.

County societies are encouraged to examine the recommendations and consider their applicability in the context of individual communities. The MSMS Committee on Aging will periodically review the experience with this approach and invites comment from member societies in this regard.

Copies of the complete recommendations are available from the Division of Chronic Disease Control, Michigan Department of Public Health, PO Box 30035, Lansing, 48909.

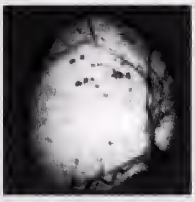
Doctor Holmes is with the Michigan Department of Public Health and is a member of the MSMS Committee on Aging.

WE HAVE A SOLUTION FOR A DIFFICULT UROLOGICAL PROBLEM

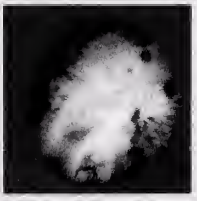
The Problem

SYMPTOMS:

EARLY
INTERSTITIAL
CYSTITIS



CLASSICAL
INTERSTITIAL
CYSTITIS



☐ irritative voiding symptoms

☐ suprapubic pain

☐ functional bladder capacity reduced

☐ anatomical bladder capacity:
EARLY — normal
CLASSICAL — reduced

☐ vesical mucosa:
EARLY — normal appearing
CLASSICAL — ulcerated, scarred

☐ submucosal vesical hemorrhages observed following second overdistension

DIAGNOSIS: INTERSTITIAL CYSTITIS

The Solution

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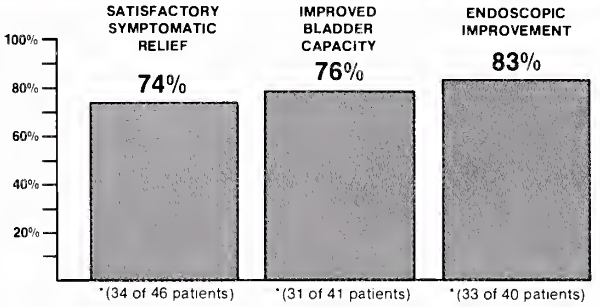
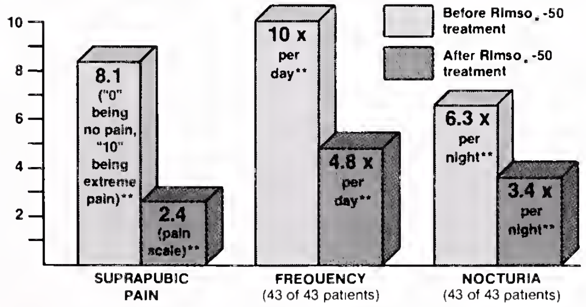


* *STEWART, B.H., et al., J. Urol., 36:116, 1976*



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Rimso®-50
(dimethyl sulfoxide)
50% w/w aqueous solution

INDICATIONS AND USAGE: Rimso®-50 (dimethyl sulfoxide) is indicated for the symptomatic relief of patients with interstitial cystitis. Rimso®-50 has not been approved as being safe and effective for any other indication. There is no clinical evidence of effectiveness of dimethyl sulfoxide in the treatment of bacterial infections of the urinary tract

CONTRAINDICATIONS: None known.

WARNINGS: Dimethyl sulfoxide can initiate the liberation of histamine and there has been occasional hypersensitivity reaction with topical administration of dimethyl sulfoxide. This hypersensitivity has been reported in one patient receiving intravesical Rimso®-50. The physician should be cognizant of this possibility in prescribing Rimso®-50. If anaphylactoid symptoms develop, appropriate therapy should be instituted.

PRECAUTIONS: Changes in the refractive index and lens opacities have been seen in monkeys, dogs and rabbits given high doses of dimethyl sulfoxide chronically Since lens changes were noted in animals, full eye evaluations, including slit lamp examinations, are recommended prior to and periodically during treatment. Approximately every six months patients receiving dimethyl sulfoxide should have a biochemical screening, particularly liver and renal function tests, and complete blood count.

Intravesical instillation of Rimso®-50 may be harmful to patients with urinary tract malignancy because of dimethyl sulfoxide-induced vasodilation. Some data indicate that dimethyl sulfoxide potentiates other concomitantly administered medications

Pregnancy Category C. Dimethyl sulfoxide caused teratogenic responses in hamsters, rats, and mice when administered intraperitoneally at high doses (2.5-12 gm/kg). Oral or topical doses of dimethyl sulfoxide did not cause problems of reproduction in rats, mice and hamsters Topical doses (5 gm/kg first two days, then 2.5 gm/kg - last eight days) produced terata in rabbits, but in another study, topical doses of 1 1 gm/kg days 3 through 16 of gestation failed to produce any abnormalities There are no adequate and well controlled studies in pregnant women. Dimethyl sulfoxide should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

It is not known whether this drug is excreted in human milk Because many drugs are excreted in human milk, caution should be exercised when dimethyl sulfoxide is administered to a nursing woman.

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: A garlic-like taste may be noted by the patient within a few minutes after instillation of Rimso®-50 (dimethyl sulfoxide) This taste may last several hours and because of the presence of metabolites, an odor on the breath and skin may remain for 72 hours.

Transient chemical cystitis has been noted following instillation of dimethyl sulfoxide. The patient may experience moderately severe discomfort on administration. Usually this becomes less prominent with repeated administration

DOSAGE AND ADMINISTRATION: Instillation of 50 ml of Rimso®-50 (dimethyl sulfoxide) directly into the bladder may be accomplished by catheter or asepto syringe and allowed to remain for 15 minutes. Application of an analgesic lubricant gel such as lidocaine jelly to the urethra is suggested prior to insertion of the catheter to avoid spasm. The medication is expelled by spontaneous voiding. It is recommended that the treatment be repeated every two weeks until maximum symptomatic relief is obtained. Thereafter, time intervals between therapy may be increased appropriately.

Administration of oral analgesic medication or suppositories containing belladonna and opium prior to the instillation of Rimso®-50 can reduce bladder spasm.

In patients with severe interstitial cystitis with very sensitive bladders, the initial treatment, and possibly the second and third (depending on patient response) should be done under anesthesia. (Saddle block has been suggested).

HOW SUPPLIED:

Bottles contain 50 ml of sterile and pyrogen-free Rimso®-50 (50% w/w dimethyl sulfoxide aqueous solution).

Dimethyl sulfoxide is clear and colorless.

Protect from strong light.

Store at room temperature (15° to 30° C).

Do not autoclave

NDC #0433-0433-05.

Stewart, B.H., et al., J. Urol., 36:116, 1976

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(99.0 + concentration)

Available in:
- 10 ml ampules, 10 ampules/case
- 70 ml bottles, 6 bottles/case
- 70 ml multi-dose containers, 6 bottles/case

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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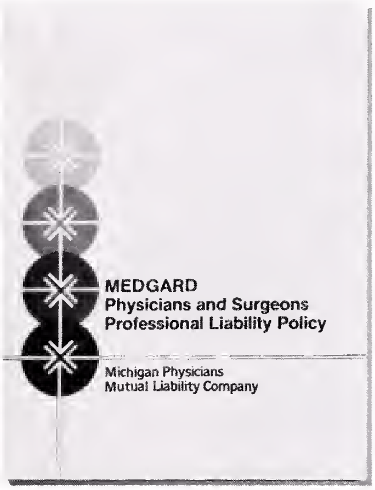
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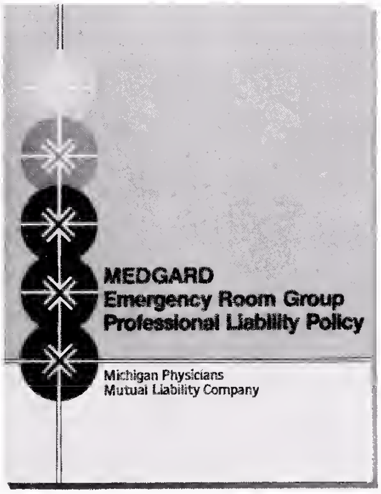
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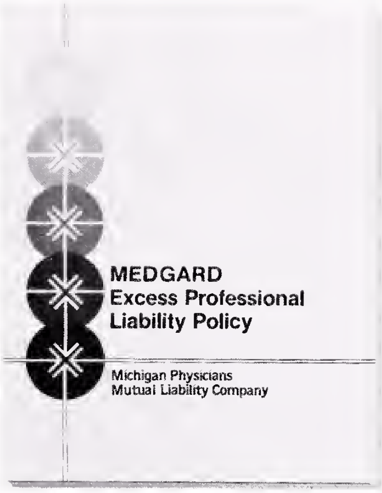
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NEWS

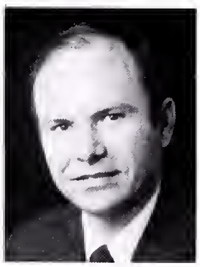
By Sheri W. Greenhoe
East Lansing

Doctor Domino

Doctor Domzalski

Doctor *Jaffar*

Doctor Swisher


Doctor Turcotte

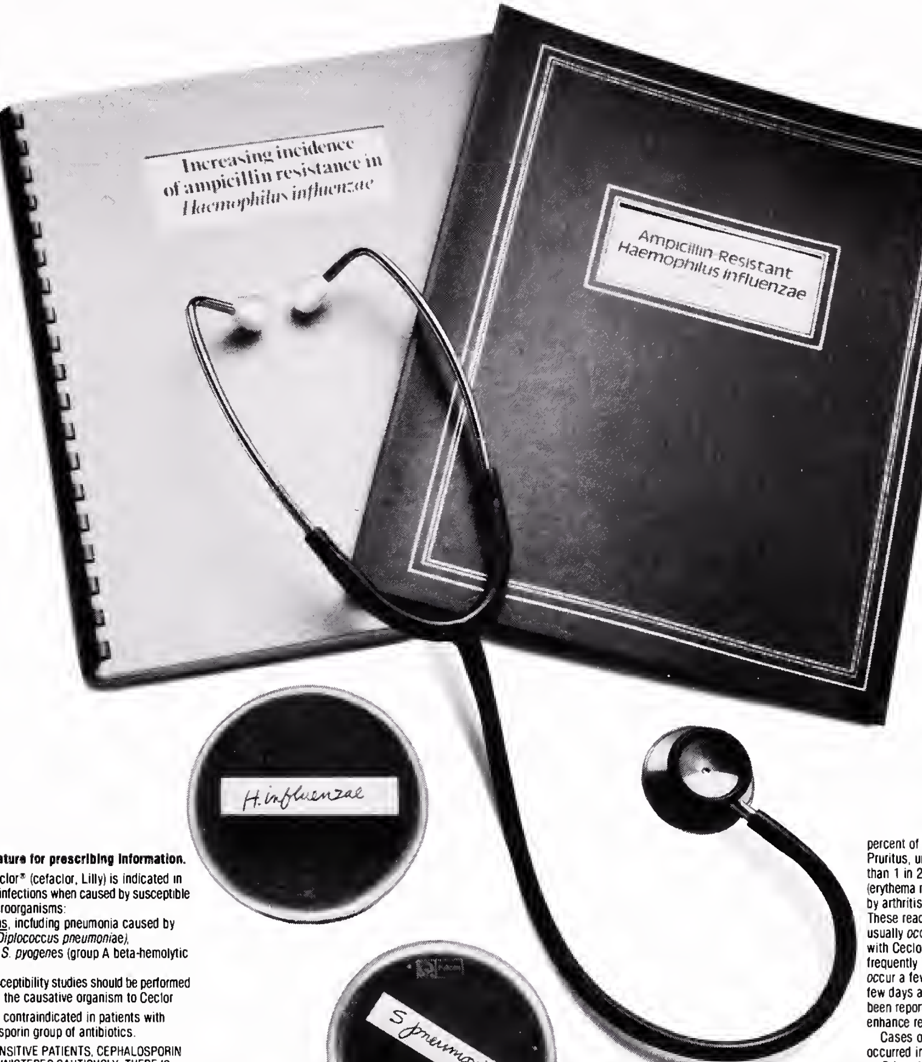
Doctor *Walt*

Scott N. Swisher, MD, professor of medicine and associate dean for research at Michigan State University's College of Human Medicine, headed a delegation of blood transfusion experts from the National American Red Cross Blood Program to the People's Republic of China for a series of visits to several major medical centers recently. . . . **Peter A. Ward, MD,** professor and chairman of the department of pathology in The University of Michigan Medical School has been named interim dean of the Medical School. Doctor Ward succeeds **John A. Gronvall, MD,** who stepped down after serving 12 years as dean. . . . Pontiac General Hospital has dedicated its maternity unit in honor of **Harold A. Furlong, MD,** in recent ceremonies. Doctor Furlong, who retired from his 50-year medical career in 1976, served as the hospital's first chief of OB/GYN. . . . **Henry M. Domzalski, MD,** urologist, is the new president of the Wayne County Medical Society. He was installed during ceremonies at the Inaugural Ball and at the 132nd Annual Meeting of the Society recently. . . . **Emanuel Tanay, MD,** clinical professor of psychiatry at Wayne State University School of Medicine, argued for the retention of the insanity defense in a recent debate during the American Psychiatric Association's annual meeting in Toronto. Abraham Halpern, MD, New York, presented the opposing arguments. . . . Recipient of the highest award of the American Urological Association, the Ramon Guiteras Award, is **Donald J. Jaffar, MD,** Southfield. The award recognizes outstanding accomplishments in the art and science of neurology. Doctor Jaffar is the former acting chairman of the Department of Urology at Wayne State University, and served as AUA president in 1969-70. . . . Several physicians from the University of Michigan Hospital's department of surgery have been honored: Department Chairman **Jeremiah G. Turcotte, MD,** has been named a member of the American Board of Surgery and president-elect of the F.A. Coller Surgical Society; **John W. Konnak, MD,** became president of the Transplantation Society of Michigan; **Walter M. Whitehouse, Jr., MD,** received a Horace H. Rackham Grant; and **Robert Dempsey, MD,** won the Paul Rosenbluth Award for resident research from the Central Neurosurgical Society. . . . New president of the American Society of Clinical Investigation is **William N. Kelley, MD,** chairman of internal medicine at The University of Michigan Medical School. He will assume the presidency in May, 1983. . . **Fred H. Ayers, MD,** was appointed a member of the board of directors of The Commercial Bank of Menominee recently. Doctor Ayers is deputy medical examiner of Menominee County, and a member of the board of trustees for Menominee County Lloyd Hospital. . . **Winthrop D. Hall, MD,** Dearborn, was honored at a surprise party recently on the occasion of his retirement from 45 years of medical practice. Doctor Hall was presented with a citation from Dearborn's mayor for service to the community's residents, and with a commendation from Cong. John Dingell. . . . **Alexander Walt, MD,** Huntington Woods, was recently appointed to represent the American Board of Surgery on the American Board of Medical Specialties and the American College of Surgeons on the Council of Medical Specialty Societies. Doctor Walt is chief of surgery at Harper-Grace Hospitals. . . . 1982 recipient of the Becton Dickinson Career Achievement Award is **William D. Ensminger, MD, PhD,** associate professor, Clinical Research Center, U-M Medical Center. The award, presented under the auspices of the Association for the Advancement of Medical Instrumentation Foundation, honors Doctor Ensminger's development of a totally implantable drug delivery system for regional cancer chemotherapy. . . . **J. Hugh Lewis, MD,** Wyandotte pediatrician for more than 56 years, retired from medical practice recently. The 83-year-old downriver physician is one of only two doctors still living who were practicing in the area when Wyandotte General Hospital opened its doors in 1926. . . . **George D. Stilwill, MD,** orthopedic surgeon at Sparrow Hospital, Lansing, was recently appointed to the National Emergency Medical Services Committee. . . . U-M Medical School professor of pharmacology, **Edward F. Domino, MD,** has been appointed to the US Army Medical Research and Development Committee by Secretary of Defense Caspar Weinberger. . . .

Continued on page 460

Ms. Greenhoe is editorial secretary to *Michigan Medicine.*

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae*[8]

Note. Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
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4. Antimicrob. Agents Chemother., *12*:490, 1977
5. Current Chemotherapy (edited by W Siegenthaler and R. Luthy), II:880 Washington, D.C.: American Society for Microbiology, 1978
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7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E Bennett), p. 487 New York: John Wiley & Sons, 1979.

Lilly

Additional information available to the profession on request from Eli Lilly and Company. Indianapolis, Indiana 46285.

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Carolina, Puerto Rico 00630

200066

Doctor Rohrer

Doctor Sandberg

Keynote speaker at the lecture series of the Arthritis Expo '82 in Grand Rapids was **Alfred B. Swanson, MD.** In addition, Doctor Swanson spoke to several specialty societies and gave a series of lectures and surgical demonstrations at the First Social Security Hospital in Lima, Peru recently. His visit there was part of Volunteer Visiting Professors Program, of which Doctor Swanson is organizer and director. **Genevieve deGroot Swanson, MD,** also of Grand Rapids, lectured to the Orthopaedic Society and to the Plastic and Reconstructive Surgery Society in Lima, Peru as part of the same program. . . . **Max Karl Newman, MD**, Southfield, and his sons, Doctors Steven and Donald Newman spoke at the American Trial Lawyers Association Conference on Worker' Compensation in Toronto recently. They addressed "Preparation of Medical Proof — The Key to Success" and "Workers' Compensation and Heart Disease: From the Physician's Point of View."

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Developer of xeroradiography for the detection of breast cancer, **John Wolfe, MD,** was awarded the Ellen G. Martin Award for Humanitarian Services by Hutzel Hospital. Doctor Wolfe celebrates his silver anniversary as a member of the hospital's professional staff this year . . . **Marsha Rohrer, MD,** Mason, was recently appointed to the Ingham County Board of Health by the Ingham County Board of Commissioners. Doctor Rohrer is the only physician member of the Board of Health . . . **Harry Grunbaum, MD,** Jackson obstetrician, was honored at a community reception upon his retirement from 50 years of practice recently. Doctor Grunbaum estimates he has delivered more than 11,000 babies . . . Grand Rapids orthopedic surgeon **B. Alfred Swanson, MD,** was awarded $2,500 for his research in flexible silicone implants in the hand by the American Academy of Orthopedic Surgeons. Doctor Swanson is contributing his award, one of the nation's highest awards for medical research, to a fund for research prizes for orthopedic surgery residents. . . . Nine long-term Providence Hospital physicians were honored at a recent dinner dance at Detroit's Renaissance Center. They are **Gerald J. Aben, MD,** Wyandotte; **Gerald Adamian, MD,** Southfield; **Donald I. Bryan, MD,** Dearborn; **Richard Donovan, MD,** Detroit; **Arch Kane, MD,** Birmingham; **Vincent J. Marecki, MD,** Dearborn; **Eugene Otlewski, MD,** Southfield; **James Pingel, MD,** Birmingham and **Oscar Schwartz, MD,** Huntington Woods. . . New president of the Wayne State University School of Medicine Alumni Association is **Hershel Sandberg, MD,** of Southfield. Doctor Sandberg, a graduate of the class of 1953, is chief of endocrinology at Sinai Hospital in Detroit. . . . **Arthur Wierenga, MD,** Jackson, and his wife recently returned from a short-term mission to Honduras, where they were part of a medical team that provided needed services to 23 towns and villages. The mission was sponsored by the Medical Group Missions program of the Christian Medical Society, although participants in the project paid their own expenses. . . . **E. James Potchen, MD,** East Lansing, has been named to the Medical Radiation Advisory Committee of the Food and Drug Administration. His appointment was made by Secretary of Health and Human Services, Richard S. Schwieker. . . . **Lionel Swan, MD,** Detroit, was honored by the Detroit Rosedale Club recently, for his contributions to medicine and civil rights. Doctor Swan is founder and president of the Detroit Medical and Surgical Center, a facility geared to meet the medical needs of the city's poor. . . . **Noemi Faustino, MD,** Buchanan internist, was awarded the second annual Doctor Albert Weiland Award by Advanced Health Systems, Inc. at an annual meeting in California. The award is presented to a doctor in the AHS network who most demonstrates the spirit of the care provided by the late Doctor Weiland of Advanced Health Systems. . . . In honor of the physicians of Ottawa County, the Ottawa County Medical Society Auxiliary donated $50 to the West Michigan Poison Control Center of Grand Rapids. The donation was made in conjunction with National Doctor's Day recently. . . . State Representative **L. Jean Willoughby,** Bloomfield Hills, was recently named "Mother of the Year" by the Michigan Mothers Association of the American Mothers, Inc. Rep. Willoughby, a member of the Oakland County Auxiliary, is married to **William A. Willoughby, MD,** an opthalmologist. . . . New Director of the Wayne State University/Harper-Grace Hospital Family Practice Residency Program is **Robert J. Toteff, MD,** Detroit. Doctor Toteff was formerly director of a Saginaw family practice residency program, and currently serves as Vice Chairman of the State Health Care Coordinating Committee. . . . **Joseph H. Shaffer, MD,** recently honored by the American College of Physicians for loyalty and longstanding membership, resides in Birmingham, not in Boynton Beach, Florida, as we reported in April.

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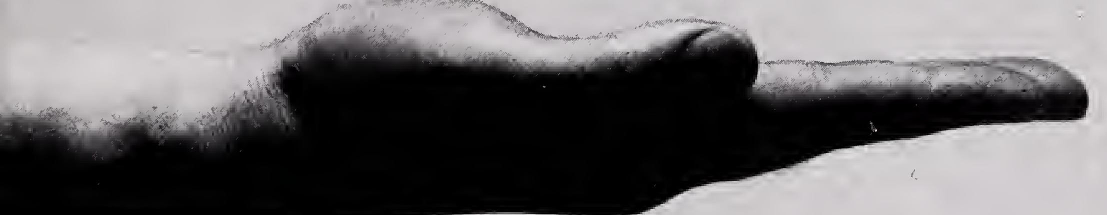

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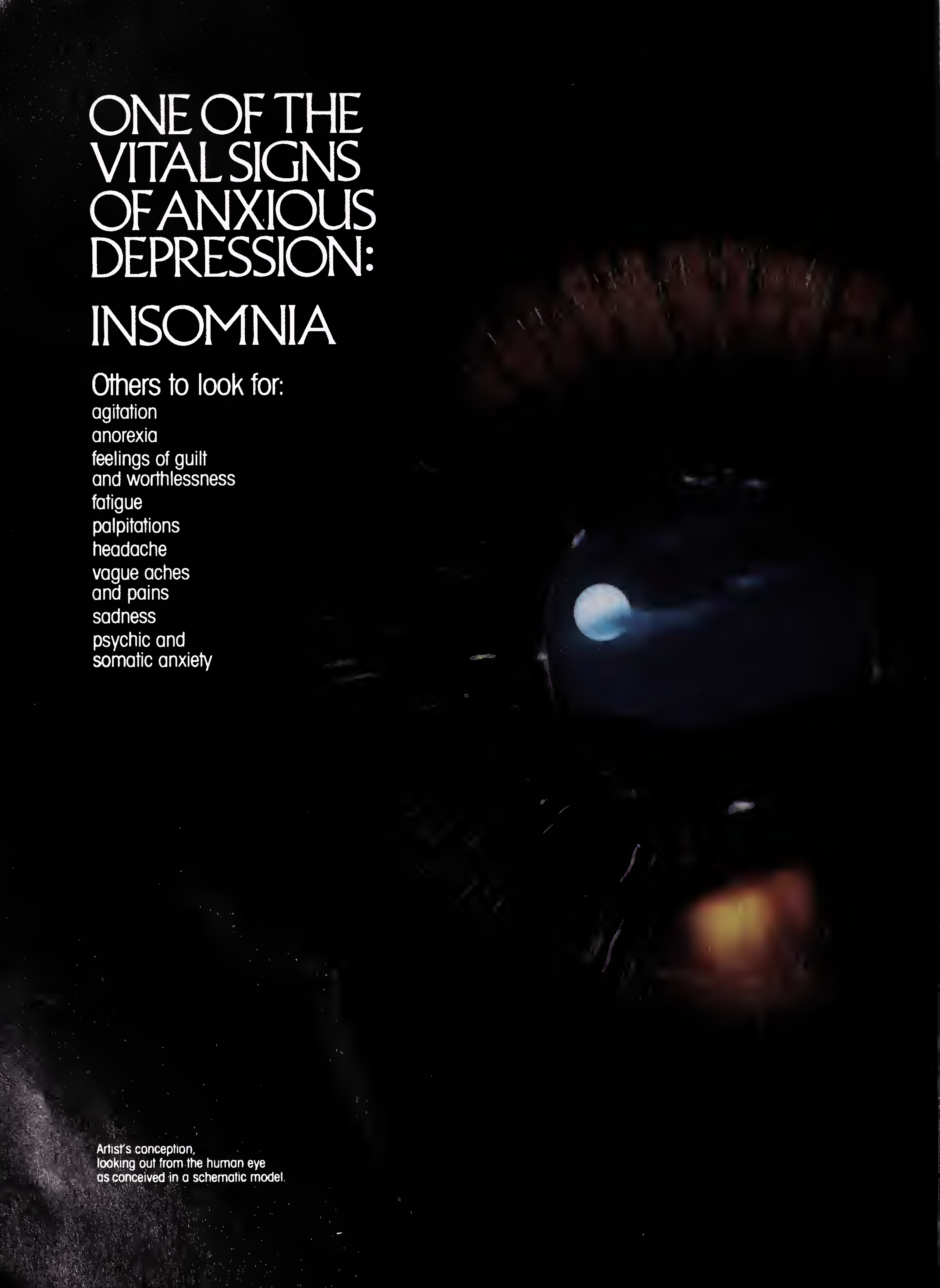

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headache
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and pains
sadness
psychic and
somatic anxiety

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looking out from the human eye
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Limbitrol brings a special—and specific—quality of relief to most anxious depressed patients. Insomnia, for example, responds with particular promptness. Other symptoms likely to respond within the first week of treatment include anorexia, agitation and psychic and somatic anxiety. And, as the depression and anxiety are alleviated, in many cases so are such related somatic symptoms as headache, palpitations, and various vague aches and pains.

Limbitrol given once daily h.s. may be the best approach

Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

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Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

> ***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50.

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Michigan MDs support mandatory seat belt use

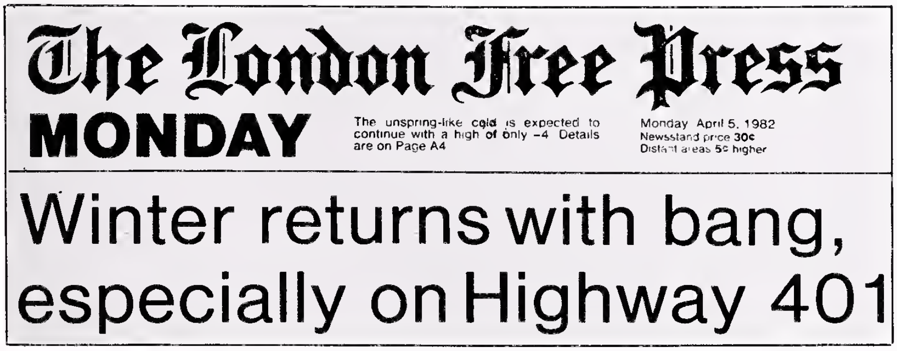
By Robert D. Burton, MD
Grand Rapids

It was Sunday afternoon, April 4, 1982.

A freak and sudden snowstorm had hit Michigan the day before and our fireplace was crackling with a cheery blaze of dried logs. The time was 2:30 p.m. when the phone rang.

"Dad? — this is Jim." (Our youngest son was making his return trip to college following the spring break and had at least 13 hours of driving before reaching Williams College in Massachusetts.)

"I'm outside of London, Ontario. The Astre is totalled. I've been in a forty car accident due to a sudden white-out. I'm OK."



The London Free Press
MONDAY
The unspring-like cold is expected to continue with a high of only −4 Details are on Page A4
Monday April 5, 1982
Newsstand price 30¢
Distant areas 5¢ higher

Winter returns with bang, especially on Highway 401

"Any injury or problem with you, Jim?"

"I've got a bruise on my left arm — that's all. And, uh, yes, I was wearing my seat belt." (My last and usual bit of fatherly advice as he was pulling out of the driveway earlier that morning.)

That episode, along with a personal seat belt habit developed the past 10 years, began with a lecture and slide presentation by Doctor Peter Fisher of Seattle. His forceful delivery and irrefutable facts presented at a medical meeting made me an advocate and strong proponent of the protection afforded by "buckling up."

The following article contains most of my presentation in the Michigan House of Representatives Chambers on May 20, when I represented the MSMS Committee on State Legislation and Regulations.

A summary of the proposed legislative high points is as follows:

1. Drivers and front seat passengers of automobiles will be required to wear safety belts which are properly adjusted and fastened.

2. Exceptions are made for the following vehicles:

a. A vehicle manufactured before January 1, 1965. Such vehicles did not have to be equipped with safety belts.

b. Bus or school bus

c. Hearse

d. Motorcycle

e. Moped

3. An exception is granted if the driver or passenger has written verification from a physician that they are unable to wear a safety belt for physical or medical reasons.

4. Failure to wear a safety belt is not to be considered evidence of negligence and shall not limit liability of an insurer nor diminish recovery for damages.

5. Violations shall be a civil infraction.

a. Points will not be assessed for a violation.

b. The fine is not to exceed $10.00-$25.00

6. The bill will be automatically sunsetted in three years.

Michigan physicians diagnose an epidemic

A doctor's training involves recognizing and combatting epidemics. When such a prestigious group as the National Highway Traffic Safety Administration predicts 70,000 road-related fatalities by 1990, we have a man-made disaster facing us.

As a result, the Michigan State Medical Society House of Delegates, representing the majority of its 10,000 members, passed the following resolution at its recent annual session:

"Whereas, a serious health problem in Michigan is related to injuries sustained in motor vehicle accidents; and

"Whereas, these injuries have a significant impact on the victim and on the remaining segment of society as well; and

"Whereas, it has been established that use of seat belts is beneficial in minimizing the extent of these injuries; therefore be it

"RESOLVED: That MSMS pursue the passage of a mandatory seat belt use law by the Michigan Legislature."

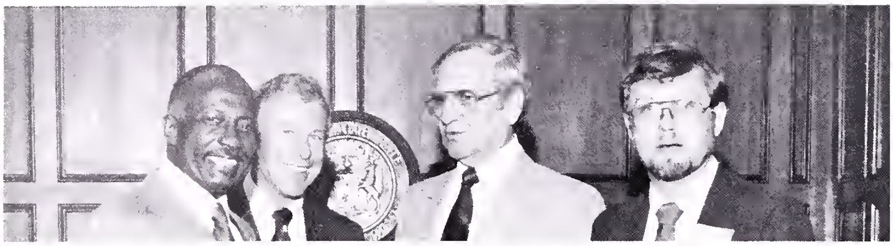
Why the big hue and cry at this time? What has made this problem gain so much recent press attention and public concern? Principally, it is the worldwide trend to producing down-sized passenger cars and lightweight trucks. In a study by J. Robert Cromack and Robert Mason published in the 1976 Southwest Research Institute Journal the collected data documents the logical safety of larger cars and belted occupants.

Presently each driver of a

Continued on page 466

Doctor Burton is chairman of the Michigan Safety Belt Coalition and is vice speaker of the MSMS House of Delegates.

SEAT BELTS/*Continued*



Doctor Burton, second from left, with other leaders in campaign for mandatory seat belt law. From left, they are Secretary of State Richard Austin, Chrysler Corporation Chairman Lee Iacocca, and State Representative David Hollister (D-Lansing).

motorized vehicle should ask himself or herself three questions:

- What could be wrong with the other drivers?
- What might happen to me?
- What options do I presently have?

In regard to the first question, the medical causes of road-related accidents have been evaluated and categorized by many studies. Over 55 percent of the so-called medical causes of such accidents can be traced to impaired judgment and performance due to alcohol and drug abuse. Breath analysis and saliva tests for alcohol excess and recently for marijuana intoxication following accidents verify this. About 35 percent of impaired judgment and performance can be traced to effects of the aging process, especially affecting the body's special senses. Another 10 percent can be traced to neurological and psychological factors such as anger, aggression, hostile personality traits and fatigue. These also may play an adverse role.

In addition, situations may arise where inexperience, as noted in the novice driver and inattention, as seen in the "harried housewife syndrome," can be accident-producing.

The second question which refers to the medical trauma problem involves specifically a human collision. In an auto accident there is a collision of the vehicle with an object, but the collision of importance is the human collision pertaining to the forces to which the human body is subjected.

What can I do?

Finally, there is the third question of "What can I do to protect myself and my loved ones?"

The classic study carried out in Sweden in which 28,000 auto accidents were analyzed leads us to an amazing conclusion. If a person was wearing a seat belt and the car involved was travelling 60 miles per hour or less no fatality occurred!! This result has been supported in subsequent crash studies with practically identical results.

Other countries have been in the lead with spectacular statistics. For example, when Belgium instituted a mandatory seat belt law there was a 54 percent decrease in deaths in the first four months.

In our state, studies by the University of Michigan estimate that 300 persons or more could avoid death each year and that over 8,200 persons could avoid serious injury by the enactment of such legislation.

Every positive action has its detractors, however, and the principal objections usually center around the "thrown clear" theory of supporters of the "fire and water" theory.

The first theory of the advantage of being thrown clear can be dispelled by the study of motorcycle fatalities. Most of these victims are "thrown clear," yet 80 percent of them could have survived if they were in a protective restraint system. In regard to the second theory of an ensuing fire or possible submersion it must be remembered that a seat belt will probably allow a level of consciousness to be maintained so that a thoughtful escape or exit approach can be taken rather than loss of consciousness.

We are faced with an issue of public health and safety involving our patients, our loved ones and ourselves. Seat belts save lives. They are a simple prescription for survival!

Child seat belt law reviewed

On April 1st, a new law became operational in Michigan which requires the use of seat belts or other restraint devices for children under the age of four.

The law states that children under the age of one year must be properly secured by an approved child restraint system regardless of where in the vehicle the child is seated. Children between the ages of one and four years also must use a child restraint system if they are seated in the front seat of the vehicle. Children over one year of age may use a regular safety belt provided in the vehicle when transported in the rear seat.

Violation of this statute is a civil infraction of law and the driver may be fined up to $10 plus costs. This law also provides that the court shall waive the fine and costs if the driver before the court date supplies the court with evidence of purchase or rental of a satisfactory child seating system.

While this new law makes the use of seat belts and child restraint systems mandatory for children under the age of four years, it should be noted that the use of seat belts by all passengers as well as the driver is prudent. Accident crash tests show conclusively that the shell of the vehicle will protect occupants from most of the consequences of vehicle accidents if they are properly secured with the restaint systems provided. Manufacturers of motor vehicles are mandatorily required by law to provide these restraint systems and they should be used.

Several manufacturers have available for purchase restraint seats especially designed for babies and children too small for the standard seat and shoulder system.

It is the responsibility of the driver to make sure that all occupants of the vehicle and especially children are "buckled up."

This article is taken from a news summary prepared by the Michigan Attorney General's office.

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SALMONELLA TYPHI:

Multiple stool exams cultured over several weeks or duodenal intubation are the most commonly used procedures. The Entero-Test is as efficient as intubation but simpler and more comfortable. New studies have further confirmed superior applicability over other procedures.

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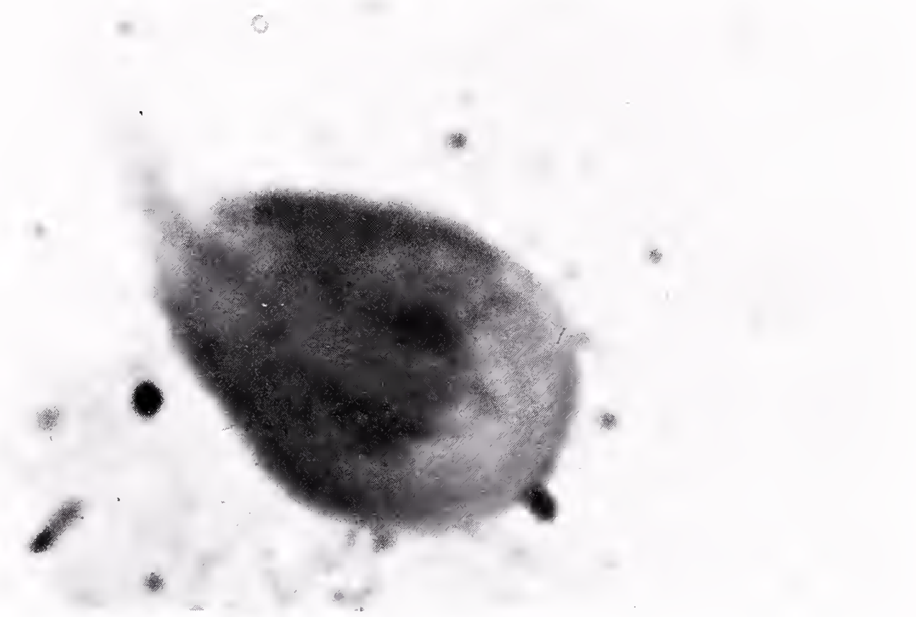
Chronic Diarrhea caused by anaerobic and aerobic bacteria in infants and children was easily identified using the Entero-Test. The string test was comparable to or better than duodenal aspirate in all cases.



Giardia lamblia

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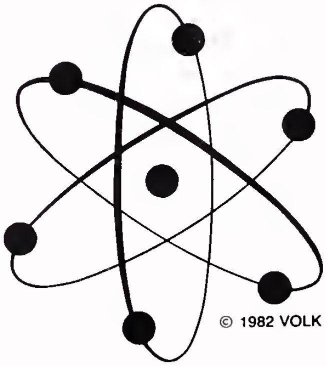
Nuclear War and Doctors

By James D. Fryfogle, MD
Southfield



I have been asked to discuss my feelings about the recent symposium against thermonuclear war held at the Music Hall in Detroit April 24. The program was entitled "The Medical Consequences of Nuclear Weapons and Nuclear War" and featured prominent speakers in the fields of medicine, human genetics, physics, pathology, and psychiatry.

The symposium was attended by about 1,000 persons.

As president of the Michigan State Medical Society, I was asked to serve as moderator of the morning session. William Anderson, DO, President-elect of the Michigan Society of Osteopathic Physicians served as moderator for the afternoon session. The sponsoring organization of the symposium was the Physicians for Social Responsibility, a non-profit organization designed to educate the physician and the public acout the medical consequences of nuclear weapons and of nuclear war.

The objectives of the symposium were to:

1. Describe the prompt and delayed effects of nuclear war.
2. Describe the medical community's past experience with a thermonuclear explosion.
3. Understand the medical-surgical injuries and psychosocial trauma which would occur if a large metropolitan city such as Detroit was the site of a nuclear explosion.
4. Interpret the effects of the arms race on health care.
5. Recognize the limits of medical care to handle adequately the medical problems following a nuclear explosion and, thus
6. Emphasize the absolute necessity of prevention.

Doctor Fryfogle is immediate past president of MSMS.

My impressions

I was impressed by several things:

First, the model used was the 1945 bombing of Hiroshima and Nagasaki. The bombs used in these cities were relatively small, as compared to today's — a one megaton (one million ton equivalents of TNT) bomb is about 85 times as powerful as the Hiroshima device. Today's bombs are of the 10 to 20 megaton capacity so that it is almost impossible to grasp the vastness of their destructive capability.

A single bomb used in Hiroshima killed 200,000 of the city's population and the survivors envied the dead. Detailed studies of these survivors have been made for the last 30 years, tracing the effects of thermonuclear burns and radiation. The psychic pathology, hematologic (leukemia) and genetic consequences read as a horror story unmentionable.

Today's arsenal of 50,000 megaton bombs, held by six countries with 12 more governments having the potential to produce nuclear bombs, could easily destroy the world as we know it.

I was prepared for the disturbing presentations of the symposium, as I had reviewed the film "The Last Epidemic" which details the destruction of a bomb falling on San Francisco. However, to see the effects on Detroit and the geography familiar to me utterly devastated, painted an unforgettable picture. All of Wayne County, much of Southern Oakland County, Southwest Ontario, Macomb County beyond Mt. Clemens and Eastern Washtenaw County would be affected. Three and one-quarter million people would be killed or injured, no habitable housing would be left, and all industry would be destroyed.

The terror, incalculable social and psychological destruction, the epidemic bacterial and viral disease, starvation with attendant violence over food and water supply, the progressive onset of radiation sickness, the great mounds of human and animal dead to be disposed of and the mobilization of the remaining medical, governmental, agricultural and technical personnel needed to begin the repair of the damage, would make the terrible destruction seen at Hiroshima and Nagasaki from two tiny thermonuclear devices seem like a surface wound.

Doctors involved

I was particularly interested in the people who attended the symposium. A doctor group occupied the center section. Many were accompanied by their wives. Most were over 45 years of age. There were few young physicians. Many were my friends whose medical judgment I value. All were concerned with the theme of the symposium and during the lunch break many expressed a desire for positive action. Many were pleased that Wayne State University sponsored the program and some joined the Physicians for Social Responsibility group that day. For some it was an old fear reactivated.

The largest group was composed of men and women with a paramedical or university relationship. All ages were represented. They seemed to be more aggressively for the program's hard line. Their response to the speakers was enthusiastic and the questions asked during the discussion portion were directed at re-emphasis on major points already made by the speakers.

A busy college age group served to staff this large gathering and they did their job well.

I met during the breaks with representatives of organized labor, members of state and local government, federal planners, and members of the clergy.

Of all the presentations, that of Jerome D. Frank, MD, Emeritus Professor of Psychiatry at Johns Hopkins University School of Medicine, was the most satisfying. He assured us that we are not alone in our fear of a nuclear holocaust, that television programming with the same message has been shown in Russia and its satellites, and that concern for the consequences are real and are being publicized throughout the Communist world.

This brings us to the thesis of Helen Caldicot, MD (Harvard Medical School). She believes this final medical epidemic, thermonuclear war, can be averted by a concerted and urgent campaign conducted by physicians throughout the world, united by an allegiance to the Hippocratic Oath. Physicians are committed to the maintenance of health and human survival. Physicians bring excellent credentials to the task of public education on this subject. Their educational role in society on all issues pertinent to health and life is widely recognized. Physicians share tradition, language and practices that transcend national boundaries. This common ground enables them to initiate dialogues with foreign colleagues and to join together to make their collective voices heard throughout the world. Thus the physicians of the world make up a natural constituency, a potentially forceful, non-political pressure group, for the rational control of these destructive weapons.

MSMS, AMA

The American Medical Association and the Michigan State Medical Society have both voiced strong support against the use of nuclear weapons. Resolution No. 28 of the 1982 House of Delegates of the Michigan State Medical Society reads:

"RESOLVED: That MSMS recognize the catastrophic danger to all life in the event of nuclear war and support efforts for the prevention of such a nuclear holocaust by encouragement of global nuclear disarmament; and be it further

"RESOLVED: That MSMS recognize that nuclear war represents one of the world's greatest health hazards and call upon its members to inform themselves, their colleagues and the general public about the medical consequences of nuclear war; and be it further

"RESOLVED: That the MSMS Council investigate the appropriateness of establishing a liaison to other organizations concerned with the medical consequences of nuclear war such as Physicians for Social Responsibility."

The Physicians for Social Re-

Continued on page 472

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MEDICAL NEWSFRONTS

Although insulin keeps millions of diabetics alive, it does not halt the life-threatening effects of excess blood sugar clogging small blood vessels of their vital organs.

University of Michigan Hospitals have begun offering diabetics two new out-patient services which act together somewhat like a semi-automatic pancreas to avert the sludge-like action of sugar's metabolic residues in restricting circulation.

The new services are a belt-worn pump which administers insulin continuously and an easy-to-use home blood sugar test to determine to what degree insulin is "burning up" blood sugar.

Together, U-M physicians believe, the new techniques should allow some diabetics to better control their critical insulin-sugar balance. This, in turn, will retard or possibly avoid long-term complications such as heart disease, blindness and kidney failure.

It is now feasible for some women facing a mastectomy operation to have the option of immediate breast reconstruction, provided this is the joint recommendation of their cancer and plastic and reconstructive surgeons.

Recent improvements in medical technology have made this choice possible for selected low risk mastectomy patients.

A well-documented three year study shows favorable patient reaction to initiation of breast reconstruction following a cancer operation during the same hospital visit, according to an article in the April issue of *Plastic and Reconstructive Surgery*, the official journal of the American Society of Plastic and Reconstructive Surgeons (ASPRS).

The study covers 30 mastectomy patients at Bryn Mawr Hospital, Bryn Mawr, PA, from 1978-81. It indicates medical success in providing breast restoration to qualified cancer patients right after mastectomy, and endorsement of the procedure by the patients themselves, based on indepth interviews.

Some couples who find themselves unable to have children may have too much in common, according to new research by infertility experts at The University of Michigan Women's Hospital.

Alan E. Beer, MD, U-M professor of obstetrics and gynecology and chairman of that department at the hospital, reports research indicates that too great a similarity in the genetic makeup and tissues of unrelated husbands and wives can cause healthy fetuses to abort naturally and spontaneously.

Reporting on an ongoing study at the U-M, Doctor Beer said the genetic problem that has prevented these normal births can be solved through relatively simple medical treatment.

Vaccinating the wife with a blood component from her husband, Doctor Beer explained, "tends to make the wife's immunological system react to the fertilized egg as dissimilar tissue, which is protected from the kind of attack that causes spontaneous abortions."

The body heat which joggers and other exercise enthusiasts build up may produce more than just sweat, according to two physiology researchers at The University of Michigan Medical School.

"Jogging fever," the average four degree rise in body temperature experienced during and lingering after exercise, may actually be good in the same way that a mild fever during the beginning of an infection may help ward off more serious illness.

Evidence of this link between illness fever and jogging fever was presented April 23 at the annual meeting of the Federation of American Societies for Experimental Biology by U-M investigators Joseph G. Cannon and Matthew J. Kluger, PhD.

They reported on research at the U-M which indicates that endogenous pyrogen, which stimulates the body to produce fever during infections, may also cause part of the temperature rise (to about 102.4 F) humans experience from exercise.

If they are right, people who exercise regularly may get sick less often because their jogging or exercise fever may kill beginning infections.

An anti-cancer drug that was synthesized and developed by a University of Michigan pharmacy researcher has been approved by the Food and Drug Administration for evaluation in human cancer patients after a 13-year refinement and testing process.

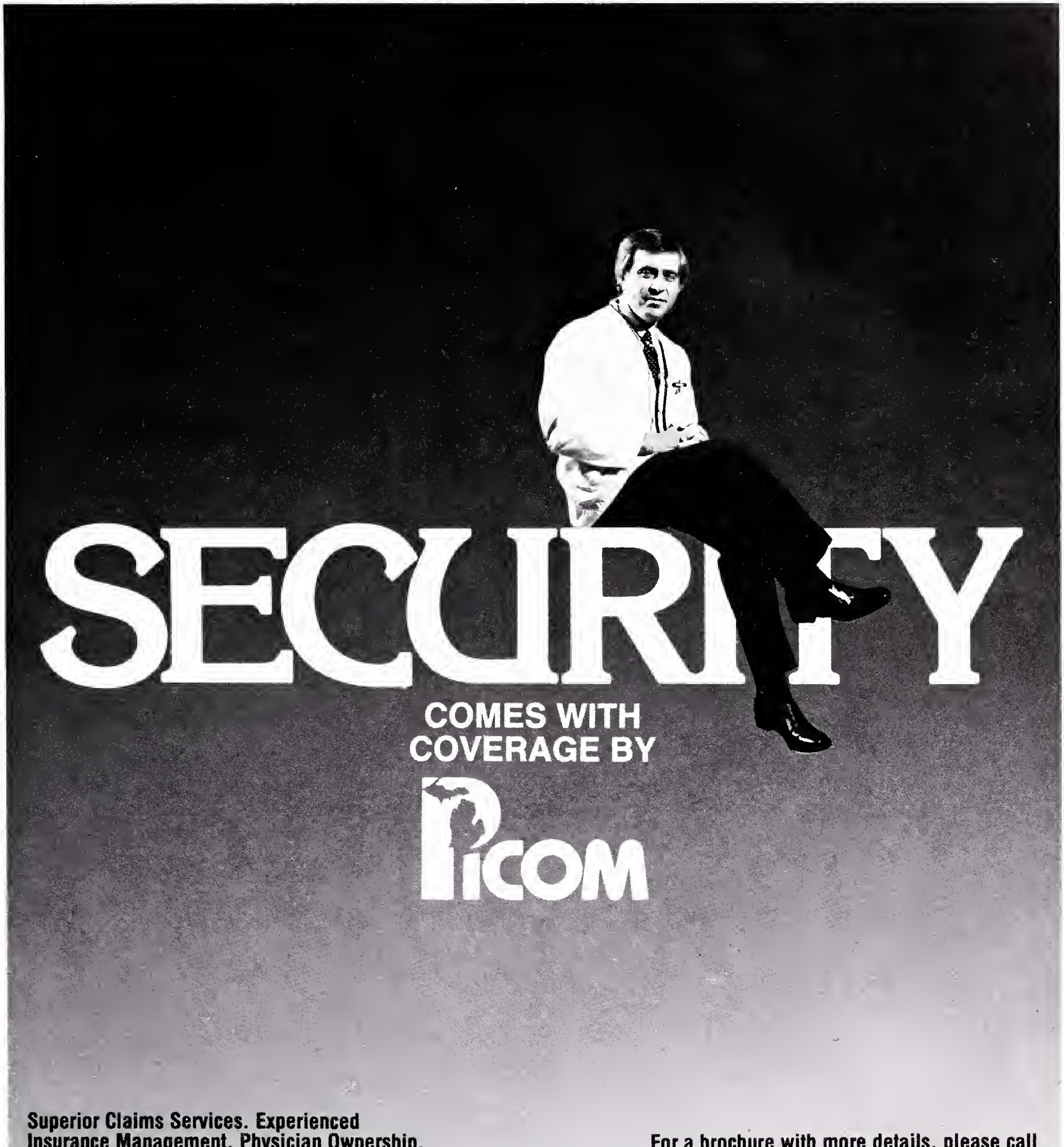
The drug, tricyclic nucleoside phosphate, was developed by Leroy B. Townsend, PhD, professor of medicinal chemistry, and his colleagues at the U-M College of Pharmacy.

Just how tricyclic nucleoside phosphate attacks cancer is not known, Townsend said, although Linda L. Watring, PhD, assistant professor of medicinal chemistry, has been studying the mechanism of act

University of Michigan psychiatrists have begun a psychiatric service for infants in the hope of preventing serious psychological problems or child abuse from arising later in the parent-child relationship.

Antal Solyom, MD, director of the Infant Psychiatry Program at the U-M Children's Psychiatric Hospital, says the program is particularly concerned with "the infant-at-risk." These include infants born prematurely or with an illness, infants born to teen-age mothers or single women and infants living in a home where there are such problems as poverty, parental illness, alcoholism, or drug abuse. But Solyom adds that emotional problems also arise among infants whose families are not in the "at risk" category.

"The infant may show signs of an emotional disturbance," Solyom says, "because the infant can't tell parents directly what's going wrong with the relationship. But the problems the infants exhibit — trouble with sleeping, eating, language development, for example — offer clues to the psychiatrist."



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CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: August 21, Ethics, The Law, and Medicine: Who's In Charge Here? Location: Fairlane Manor, Dearborn. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $95. **Contact:** Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, University of Michigan, Ann Arbor 48109, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: Aug. 23-27, Tutorial on Direct Action Thrusting. Location: Lansing General Hospital. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date Aug. 25. Dermatology for the Practitioner: New Developments. Location: Towsley Center, University of Michigan, Ann Arbor. **Sponsor:** U-M Office of CME, Department of Postgraduate Medicine and Health Professions Education. **For (Specialty):** Family and general practitioners, internists, pediatricians, emergency physicians and all other health care professionals who need practical approaches to the management of common skin problems. **Cost:** $95. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 8 hours of Category I Credit.

Date: August 26-28, Advanced Cardiac Life Support. Location: Saint John Hospital Education Center, 22101 Moross Road, Detroit. **Sponsor:** Saint John Hospital. **Cost:** $200. **Contact:** Nursing Education Department, Saint John Hospital, 22101 Moross Road, Detroit 48236. **Approved for:** 20 hours of Category I Credit.

Date: Aug. 27-30, Advances in the Management of Infectious Diseases. Location: The Grant Hotel, Mackinac Island. **Sponsor:** Department of Internal Medicine and Office of CME, Department of Postgraduate Medicine and Health Professions Education, U-M. **For:** Internists, family physicians, pediatricians and other primary care physicians. **Cost:** $255. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 11 hours of Category I Credit.

Date: August 28-29, Anatomy and Techniques of Regional Anesthesia. Location: Gordon Scott Hall, Wayne State University School of Medicine. **Sponsor:** WSU Division of CME. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, 9B DRHUHC, Detroit 48210 (313) 577-1180. **Approved for:** 12 hours of Category I Credit.

Date: September 8-9, 1982 Western Michigan Trauma and Critical Care Symposium. Location: Butterworth Hospital, Grand Rapids. **Sponsor:** Butterworth Surgical Education and Nursing Departments. **Cost:** $75 for two days or $45 for one day. **Contact:** Beth DeVriendt, Butterworth Hospital, (616) 774-1405. **Approved for:** 12 hours of Category I Credit.

Date: September 9-11, Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, Chairman, 290 Blodgett Professional Building, 1900 Wealthy St., SE, Grand Rapids, 49506. **Approved for:** 19 hours of Category I Credit.

Date: Sept. 10, "Seventh Annual Cardiac Rehabilitation and Exercise Testing Symposium." Location: Borgess Medical Center, 1521 Gull Road, Kalamazoo. **Sponsor:** Borgess Medical Center/Southwestern Michigan Area Health Education Center. **Cost:** $65. **Contact:** Laura Denman, MS, Cardiac Rehabilitation Institute, Borgess Medical Center, Kalamazoo, 49001 (616) 383-8342. **Approved for:** 7 hours of Category I Credit.

Date: September 10-12, Fifth Annual Court in Diagnostic Ultrasound. Location: Towsley

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NUCLEAR WAR/*Continued*

sponsibility's credo is that:

"1. Nuclear war, even a "limited" one, would result in death, injury, and disease on a scale that has no precedent in the history of human existence.

2. Medical "disaster planning" for nuclear war is meaningless. There is no possible effective medical response. Most hospitals would be destroyed, most medical personnel dead or injured, most supplies unavailable. Most "survivors" would die.

3. There is no effective civil defense. The blast, thermal and radiation effects would kill even those in shelters, and the fallout would reach those who had been evacuated.

4. Recovery from nuclear war would be impossible. The economic, ecologic, and social fabric on which human life depends would be destroyed in the U.S., the U.S.S.R, and much of the rest of the world.

5. In sum, there can be no winners in a nuclear war. Worldwide fallout would contaminate much of the globe for generations and atmospheric effects would severely damage all living things."

Actions needed are to:

1. Defuse the current tensions between our countries.

2. Ban the use of all nuclear weapons.

3. Recognize the threat posed by the very existence of our enormous nuclear arsenals, and begin dismantling them.

Author's reaction

Since this symposium I have received letters from physicians I respect, and numerous phone calls applauding my action and that of the State Medical Society in the support of prevention as the only treatment for the "final epidemic." I have of necessity had to increase the scope of my reading on this complex subject. I am impressed by the authors. Many are persons of international stature in medicine, science and politics, drawn together by their concern for survival.

We all should be concerned.

Center for Continuing Medical Education, Ann Arbor. **Sponsor:** Department of Radiology and Department of Postgraduate Medicine and Health Professions Education, The University of Michigan Medical School. **For:** all interested physicians. **Cost:** $275. **Contact:** David Bruce Youel, MD, Director, Office of Continuing Medical Education, Towsley Center, U-M Medical Center, Ann Arbor 48109 (313) 763-1423. **Approved for:** 16 hours of Category I Credit.

Date: Sept. 13-15, Total Joint Replacement in the Upper Extremity. Location: Towsley Center for Continuing Medical Education, U-M. **Sponsor:** American Academy of Orthopaedic Surgeons. **Cost:** $420. **Contact:** Gwen Stewart (313) 764-0221. **Approved for:** 18 hours of Category I Credit.

Date: Sept. 22-25, Fifth National Conference on the Impaired Physician: "Positive Strategies in Physician Coping." Location: Portland, Oregon. **Sponsor:** American Medical Association. **Contact:** Janice Robertson, AMA Department of Mental Health, 535 N. Dearborn St., Chicago 60610. **Approved for:** 19 hours of Category I Credit.

Date: Sept. 23, Evolutions in Perinatal Care. Location: Bay Valley Inn, Bay City. **Sponsor:** Perinatal Association of Michigan. **Contact:** Karen Brown, RN, Saginaw General Hospital, c/o Neonatology, 1447 N. Harrison, Saginaw 48602. **Approved for:** 5.5 hours of Category I Credit.

Date: September 24-26, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Sept. 25-26, 10th Annual Medical Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinic Medical Center. **Cost:** $120. **Contact:** Philip E. Hills, MD, Chairman, Burns Clinic Medical Center, Petoskey 49770 (616) 348-4500. **Approved for:** 12 hours of Category I Credit.

Date: October 13, First Kalamazoo Vascular Symposium. Location: Kalamazoo Hilton Inn. **Co-sponsor:** Regional Vascular Surgery, PC and Southwestern Michigan Area Health Education Center. **Contact:** Charles L. Zeller, Jr., M.D., Director, Continuing Medical Education, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo 49001, (616) 388-7877. **Approved for:** 5-6 hours of Category I Credit.

Date: Oct. 14-17, Annual Regional Meeting of the Michigan Chapter, American College of Physicians. Location: Traverse City Hilton. **Sponsor:** American College of Physicians, in association with the Michigan Society of Internal Medicine. **Contact:** Arnold R. Axelrod, MD, Sinai Hospital of Detroit, (313) 493-5780. **Approved for:** 25 hours of Category I Credit.

Date: October 15-16, Cardiac Rehabilitation. Location: Hyatt Regency Dearborn. **Sponsor:** International Medical Education Corporation. **Cost:** $245. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive East, Englewood, CO 80112 800-525-8651 or 303-740-8445, ext. 123. **Approved for:** 13 hours of Category I Credit.

Date: Oct. 25-29, Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

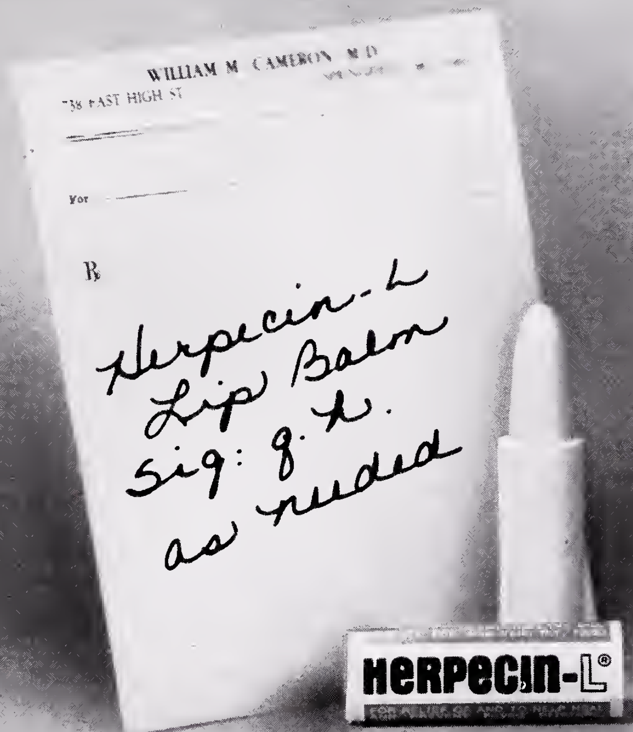
Date: Nov. 1-5, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Kellogg Center, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Nov. 8-10. Manual Medicine to the Extremities. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Nov. 9-11. MSMS Annual Scientific Meeting. Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** Sherry Fent, MSMS headquarters (517) 337-1351. **Approved for:** Up to 18 hours of Category I Credit.

Date: Nov. 20, Surrogate Mother Symposium. Location: McGregor Memorial Conference Center, Wayne State University, Detroit. **Sponsor:** WSU Schools of Medicine and Law. **For:** OB/GYNs and others interested in fertility issues. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 7 hours of Category I Credit.

Dx: recurrent herpes labialis



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his or her ability
to practice medicine?

If so, please contact your MSMS Program to Assist Impaired Physicians through Marce Ireland at MSMS headquarters, (517) 337-1351.

MICHIGAN STATE MEDICAL SOCIETY 1866

MEETINGS

of MSMS, MSMS/A, AMA, and medical assistants

Sept. 16-30 — MSMS/INTRAV Far East Adventure, contact: Marce Ireland, MSMS headquarters, 517/337-1351.

Sept. 20 — MSMS/A State Board Meeting, MSMS headquarters, contact Caroline Rich, 517/337-1351.

Sept. 20-24 — American Association of Medical Assistants, Inc., National Convention, Shamrock Hotel, Houston, Texas, contact: Caroline Rich, MSMS headquarters 517/337-1351.

Sept. 21 — MSMS Council Meeting, MSMS headquarters, contact Vada Davis, 517/337-1351.

Sept. 23 — MSMS Medical Staff Relations Conference, Wayne County Medical Society Auditorium, contact: William Madigan, MSMS headquarters.

Sept. 22-25 — AMA Fifth National Conference on the Impaired Physician, Portland Marriot, Portland, Oregon, contact: AMA, 312/751-5109, 535 N. Dearborn, Chicago, IL 60610.

Oct. 1-14 — MSMS/INTRAV Nile River Adventure, contact Marce Ireland, MSMS headquarters, 517/337-1351.

Oct. 10-12 — MSMS/A National Leadership Confluence, Drake Hotel, Chicago, contact Caroline Rich, MSMS headquarters, 517/337-1351.

Oct. 28 — MSMS Leadership/Public Affairs Conference, Long's Convention Center, Lansing, contact: Bill Madigan or Kevin Kelly at MSMS headquarters.

Nov. 6-7 — American Association of Medical Assistants, Inc. Fall Leadership Training Seminar, Kalamazoo Center, Hilton, Kalamazoo, contact: Caroline Rich, MSMS headquarters, 517/337-1351.

Nov. 8 — MSMS/A State Board Meeting, MSMS headquarters, contact: Caroline Rich, 517/337-1351.

Nov. 9-10-11 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Other meetings

Aug. 20-22 — National Convention, Physicians of India Association, Detroit, contact: Doctor Kothari, 313/644-1269. Scientific & Academic Meeting to be held Aug. 21, contact: Doctor Ravindranath, 313/643-7725.

Sept. 3-4 — State Medical Journal Advertising Bureau Biennial Journal Conference, The Grand Hotel, Mackinac Island, contact: Judith Marr, MSMS headquarters, 517/337-1351.

Sept. 9-10 — National Meetings on Physician Maldistribution, sponsored by the U-M School of Public Health, contact Department of Conferences and Institutes, U-M Extension Service, 412 Maynard Street, Ann Arbor 48109.

Sept. 9-10 — National Meeting on Physician Maldistribution, sponsored by the Physician Distribution Incentive Project of the U-M School of Public Health, Westin Hotel, Detroit, contact: Dept. of Conferences and Institutes, U-M Extensive Service, 412 Maynard Street, Ann Arbor 48109.

Sept. 17-19 — "EMS in Our Lives" conference, Michigan Association of Emergency Medical Technicians, Hyatt Regency, Dearborn, contact: MAEMT Convention Registrar, PO Box 118, Union Lake, MI 48085.

Reye's Syndrome update from MDPH

A total of 21 cases of Reye's Syndrome (RS) in Michigan residents, including seven deaths, were reported between Oct. 1, 1981 and April 30, 1982. Last year, 16 cases were reported during the same months. No new cases have been reported since April 30.

Michigan's RS cases seemed to occur in several small temporal clusters this fall and winter. The occurrence of these temporal clusters did not follow the reported incidence of influenza-like illness for the state closely. Only four of the 21 cases reported this year had onset during March, at the peak of the influenza season. No RS cases were reported in April in spite of the fact that influenza virus activity continued.

This past winter's influenza season was characterized by mild to moderate virus activity continuing over a six to eight week period from late February through mid-April, a relatively lengthy season. Type B influenza virus, which is much more commonly associated with RS, predominated. Outbreaks tended to be centered in schools with relatively low level community spread. We can't yet predict whether or not type B influenza virus will circulate in outbreak proportion next year.

No geographical clustering was observed this past season. The 21 cases occurred in 16 different Michigan counties. No county had more than two cases. Again cases from suburban and rural areas were more common that those from urban areas.

Four cases occurred in infants and two cases in one-year-old children. The distribution of cases by age was otherwise similar to last year. Eight of the cases are male; 13 are female. Five of the cases occurred in non-white children this fall and winter versus one last year.

All but two of the 21 cases this year were admitted before onset of coma. Last year three of 16 cases reported during the same time interval were admitted in coma. No deaths occurred among the seven children admitted at Stage 0 or I; however, five of 12 children admitted at Stage II and both children admitted at Stage III (coma) or greater died.

At this point there is no explanation for the 33 percent case fatality rate observed this year. This case fatality rate is higher than that observed in Michigan over the past two years. Three of the seven deaths occurred in the six children one year old or less in which RS tends to be more severe.

The State of Ohio, again, reported more cases than any other Great Lakes State. Minnesota, Indiana, Illinois and Ontario all reported seven or less cases for the six month period.

For details, contact William Hall, MD, Disease Surveillance, Michigan Department of Public Health, 3500 N. Logan, Box 30035, Lansing 48909.

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DEATHS

Robert W. Albrecht, MD
Keego Harbor

Robert W. Albrecht, MD, Keego Harbor general practitioner for more than 30 years, died June 15. He was 58. Doctor Albrecht earned his medical degree from the University of Michigan in 1949, then served in the military as a medical officer until 1951. He was on staff at Pontiac General Hospital, and was chairman-elect to that hospital's Department of Family Practice at the time of his death.

Harry Balberor, MD
Bloomfield Hills

Harry Balberor, MD, Bloomfield Hills, died June 16 at the age of 67. He had been a Detroit area internist for more than 44 years. Doctor Balberor graduated from Wayne State University School of Medicine in 1938, and served in the US Army from 1942 until 1946. He was affiliated with Sinai, Mt. Carmel Mercy and Lincoln hospitals of Detroit, and was a member of the Detroit Gastoenterology Society.

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October 29 & 30, 1982
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Andrew Whelton, MD

Contact: T. O'Connor, Medical Staff Education
Bethesda Hospital and Deaconess Association
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Cincinnati, OH 45206
(513) 559-6337, 6339
10 Category I Credits awarded for attendance

Charles J. Courville, MD
Birmingham

Charles J. Courville, MD, Birmingham, died May 7. He was 69. Doctor Courville received his MD in 1937 from the University of Michigan Medical School. A dermatologist, Doctor Courville was affiliated with Harper, Receiving, and Rehabilitation hospitals of Metropolitan Detroit. He had been a former president, secretary and treasurer of the Detroit Dermatological Society.

Laurel S. Eno, MD
Palm Springs, California

Laurel S. Eno, MD, formerly of St. Clair Shores, died May 26. He was 70. Doctor Eno, an obstetrician/gynecologist, earned his MD from Northwestern University School of Medicine in 1937. He served in Italy and the Far East with the Harper Hospital Unit during WWII. A member of the Central Association of OB/GYNs and the Detroit Medical Club, Doctor Eno was a member of the consulting staff and executive committee at St. John Hospital.

Frederick W. Giese, MD
Westland

Frederick W. Giese, MD, Westland, died June 10 at the age of 74. Doctor Giese was a 1932 graduate of Wayne State University's School of Medicine, where he studied Pediatrics. He served in the US Navy from 1943 until 1945. A member of the Detroit Pediatric Society, Doctor Giese was affiliated with Children's Hospital of Detroit, and was a member of Phi Rho Sigma medical fraternity. He was recipient of a 1982 MSMS 50-year award.

Robert K. Hart, MD
Croswell

Robert K. Hart, MD, Croswell, general practitioner since 1929, died May 17 at the age of 86. Doctor Hart earned his MD from Wayne State University in 1928. He was a WWI veteran, a life member of American Legion Post 255, and was honored by MSMS recently for 50 years of medical practice. Sanilac County Medical Society honored Doctor Hart, past president of that group, with a resolution upon his death, calling him a leader in the local medical community. Doctor Hart had been affiliated with Mercy, Port Huron, Yale Community and Deckerville hospitals.

Hugo O. Horny, MD
Murrells Inlet, South Carolina

Hugo O. Horny, MD, formerly of Grosse Pointe, died April 2. He was 74. Doctor Horny graduated from the Detroit College of Medicine in 1932. He saw medical military service from 1942 until 1946. A general practitioner, Doctor Horny practiced industrial medicine part time at Michigan Bell, and was affiliated with Grace Hospital of Detroit. He was recipient of a 1982 MSMS 50-year award.

Ross M. Knox, MD
Allen Park

Ross M. Knox, MD, Allen Park, died June 12 at the age of 81. He earned his medical degree in 1931, then launched a 50-year medical career in the downriver area. Well-known by the residents of Ecorse, Allen Park and Wyandotte, Doctor Knox was a lifetime member of the American Medical Association.

Donald A. Koch, MD
Venice, Florida

Donald A. Koch, MD, former Port Huron radiologist, died May 28 at the age of 73. Doctor Koch earned his MD in 1935 from Wayne State University, then in 1942 served the US Army in the Wayne Medical Unit in the European Theatre. He had been an associate professor of radiology at WSU, then chairman of the radiology department at Port Huron Hospital until his retirement in 1971. Doctor Koch was chief of staff at Port Huron Mercy Hospital from 1959 until 1961, and was a member of the American College of Radiologists, the Radiological Society of America and the American Roentgen Ray Society. He served St. Clair County Medical Society as its president in 1954.

Earle D. MacKenzie, MD
Southfield

Earle D. MacKenzie, MD, Southfield, died June 15. He was 85. Doctor MacKenzie was a 1920 graduate of the Detroit College of Medicine, and had been an internist on staff at

Board of Medicine Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigation and appropriate administrative action, are printed from official memoranda to MSMS and are not editorialized:

- **Melvin Hopkins, Jr., MD**

900 Baldwin Avenue
Pontiac, MI 48055

Date, action taken

June 9, 1982
Summarily Suspended
effective 6-9-82

Violation

S16221(1) — A violation of general duty.
S.16221(b)(i) — Incompetence.
S.16221(c)(iv) — Obtaining, possessing, or attempting to obtain or possess a controlled substance without lawful authority; or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes.
S.16221(g) — A violation, or aiding or abetting in a violation, of this article or of rules promulgated under this article.

- **Ali Guner, MD**

2061 N. Partridge Road
Alpena, MI 49707

Date, action taken

June 9, 1982
Suspended from
9-2-81 to 9-2-82

Violation

S.16221(a) — A violation of general duty.
S.16221(b)(i) — Incompetence.
S.16221(b)(v) — Conviction of criminal sexual conduct in the fourth degree.
S.11(2)(h) — Immoral conduct.
S.11(2)(i) — A departure from, or failure to conform to, minimal standards of acceptable and prevailing medical practice.

- **Dale L. Williams, MD**

2345 Getty Street
Muskegon Heights, MI 49444

Date, action taken

June 9, 1982
Licensee Must Submit
Specified Reports

Violation

S.11(2)(i) — A departure from, or failure to conform to, minimal standards of acceptable and prevailing medical practice.

- **John C. Watts, MD**

4637 Palmer
Dearborn, MI 48126

Date, action taken

May 28, 1982
Suspended from
4-14-82 to 9-14-83

Violation

S.16221(a) — A violation of general duty.
S.16221(c)(iv) — Obtaining, possessing, or attempting to obtain or possess a controlled substance without lawful authority; or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes.
S.16221(g) — A violation, or aiding or abetting in a violation, of this article or of rules promulgated under this article.

- **Richard A. Edlund, MD**

104 Norton Medical Center
Muskegon 49444

Date, Action Taken

March 10, 1982
Reprimand and
Probation from
3-10-82 to 3-10-83

Violation

S.1622(c)(iv) – Possession or use of a controlled substance without legal or legitimate therapeutic purpose.

Further board actions

- **RE: Joseph W. Rucker, MD**

Complaint #43-0200-76

To Whom It May Concern:

Please be advised that there has been a Stay in the Court of Appeals placed on the Board's Order dated November 14, 1980 on the above named individual.

- **RE: Leo Hirsch, MD**

Complaint #43-0663-81

To Whom It May Concern:

The disciplinary report submitted January 19, 1982 contained an action involving Leo Hirsch, MD.

Please be advised that the issuance of a limited license in the matter of Leo Hirsch, MD should not be construed as disciplinary in nature.

The issuance of a limited license was granted at the request of Dr. Hirsch.

Any further questions regarding this matter may be addressed to this office.

Robert D. Ulieru, Director
Office of Complaint Analysis
Bureau of Health Services
Lansing
Phone: (517) 373-9196

Grace Hospital for 55 years. He closed his office in 1972, yet maintained an active practice until 1975.

T. Scott Moore, MD
Muncie, Indiana

T. Scott Moore, MD, formerly of Niles, died May 22. He was 77. Doctor Moore, honored for achieving 50 years of medical practice at the 1982 MSMS House of Delegates, was a 1932 graduate of Jefferson Medical School in Pennyslvania. An ophthalmologist, Doctor Moore was a past president of Berrien County Medical Society. He had been affiliated with Pawating Hospital, and was active in Rotary, International.

Victor E. Nelson, MD
Royal Oak

Victor E. Nelson, MD, Royal Oak, died June 25 at the age of 78. A former president of Highland Park General Hospital, Doctor Nelson practiced surgery in Detroit for 40 years. He earned his MD from the University of Michigan in 1932, and was a member of the Academy of Surgery of Detroit and the Detroit Surgical Society. He was a former MSMS delegate and was honored for 50 years of medical service this year by the MSMS House of Delegates.

Carl H. White, MD
Linden

Carl H. White, MD, Linden, died June 6. He was 77. An otolaryngologist and ophthalmologist, Doctor White was an activitist in local government. He earned his medical degree in 1931 from the Detroit College of Medicine, and was recently honored by MSMS for 50 years of medical practice. Doctor White was affiliated with Hurley, St. Joseph and McLaren hospitals of Flint, and was a member of the American Academy of Ophthalmology and Otolaryngology.

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Contact: T. O'Connor, Medical Staff Education
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Referrals needed for these U-M research studies

The Silent Adrenal Lesion

This study is designed to investigate the significance of the **abnormal adrenal gland** in patients without adrenal disease as seen in many instances on abdominal CT scans. Simple enlargement of the adrenal may not signify significant disease; however, in many instances patients are subjected to further investigations when abnormal adrenal glands are seen on CT imaging. We propose to further study such patients in whom unsuspected anatomic adrenal abnormalities are found. Patients will be placed in the Clinical Research Unit at the University of Michigan Medical Center. Baseline studies of adrenal function to include cortisol, aldosterone, androgens and catecholamines will be obtained. Dyanmic tests such as dexamethasone suppression and ACTH augmentation also will be performed. Adrenal scintigraphy (a procedure developed and in clinical use at the University of Michigan Medical Center) will be performed to functionally image the adrenals. The correlation of such data will be useful in determining which patterns of adrenal imaging (both computed tomographic and scintigraphic) will require further diagnostic evaluation. We propose to study patients off medications if at all possible. Third party remuneration for the biochemical determination will be made; however, the scintigraphic evaluations will be conducted at no charge to the patient.

For referrals, please contact: Milton D. Gross, MD, VA Medical Center, Ann Arbor, 48105, (313) 769-7100, Ext. 406; or, Brahm Shapiro, MD, University of Michigan Medical Center, Ann Arbor, 48109, (313) 764-3253.

Plasmapheresis in the treatment of acute Guillain-Barre Syndrome (GBS)

The University of Michigan Neurology Department is participating in a national cooperative study of the effects of plasma exchange on the treatment of acute GBS. Eligible patients are admitted to the study and randomly assigned to either a plasma exchange or conventional medical treatment group. Non-ambulatory patients, 12 years of age or older, who have had GBS for less than 30 days are eligible. Patients receiving plasma exchange have those costs covered by the grant and all study patients may be admitted to the Clinical Research Unit unless intensive care is required. The study began in March 1981 and will be completed in the summer of 1983.

For referrals, please contact: James W. Albers, MD, PhD, Dept. of Neurology, B4915 CFOB, Univ. of Mich. Med. Center, Ann Arbor 48109, (313) 763-4725, or call paging operator at (313) 764-4244 and ask for the neurology resident on call.

Determinants of furosemide response in nephrotic patients

It has been observed that some patients with nephrotic syndrome are refractory to furosemide, requiring large doses to achieve adequate diuresis. Individual response is variable and difficult to predict clinically. Several mechanisms have been suggested to explain this lack of effect. These include changes in furosemide metabolism, a reduced glomerular filtration rate, a decrease in renal tubular transport, as well as a reduced amount of free furosemide within the tubular lumen. Since furosemide is highly protein bound and only the free drug produces the desired diuretic effect, it is possible that in these unresponsive nephrotic patients the diuretic is being eliminated bound to urine protein.

The specific objectives of this study are:

1. To study the pharmacokinetics and pharmacodynamics of intravenous furosemide in nephrotic patients when administered alone and after sulfisoxazole pretreatment.
2. To determine the role of plasma and urinary protein binding of furosemide in effecting the drug's natriuretic and diuretic response in nephrotic patients.

Both male and female patients with proteinuria $>$ 3.5 gm/day and a relatively stable creatinine clearance $>$ 30 ml/min will be considered for the study. Patients with congestive heart failure, liver disease, or with a known allergy to sulfa drugs will be excluded from the study.

Patients who complete the two phases of the study (Phase I — furosemide alone; Phase II — furosemide with fulfisoxazole pretreatment) will be paid $150 for their participation.

For referrals, please contact: Doctors Hyneck or Berardi, The University of Michigan College of Pharmacy, Ann Arbor 48109, (313) 764-7312 or (313) 763-6629.

PRESIDENT'S PAGE

FTC and the professions: let's tell Congress our views

By James H. Tisdel, MD
MSMS President

This article is prepared from material provided by the AMA.

The issue of the Federal Trade commission's assumed jurisdiction over the professions soon may be settled by the Congress.

The decision is important not only for us as physicians but also for our patients. At stake for the medical profession is our right to set standards to protect the public from deception and incompetence in the medical profession. At stake for individual states is the right to enact laws pertaining to professionals and professional organizations without threat of having them preempted by a nonelected agency. At stake for patients is their right to have qualified and experienced medical professionals responsible for professional self-regulation that embraces a commitment to serve the public and improve the quality of life in our society.

The medical profession is concerned that its position regarding the FTC has not been clearly understood by the public. The American Medical Association, in its long battle with the FTC, has not been asking for exemption from federal antitrust laws as implemented by the US Department of Justice. The medical profession is asking that claims of improper conduct by professional groups be tried in courts with impartial judges rather in administrative hearings before salaried employees of the agency making the charges.

The medical profession firmly believes that Congress did not intend to establish a Federal Trade Commission to regulate professional associations and to preempt duly enacted state laws governing the professions. The FTC was established to supplement the Sherman Act in those areas of industrial and commercial business in which regulation by an administrative agency with business expertise was believed more desirable than judicial enforcement. The FTC, with its commercial orientation and narrow focus, simply does not have the expertise to evaluate professional activities of nonprofit professional associations.

The American Medical Association, from first-hand experience, has become acutely aware of the staggering costs and enormous burdens incurred in responding to an FTC complaint. The AMA knows only too well that medical associations face an unacceptable choice when confronted by the FTC. They must either divert scarce resources from socially beneficial activities to defend against unfounded FTC charges or simply capitulate because of the overwhelming amount of time and money needed to defend meritorious positions.

The medical profession, through the AMA, has urged enactment of legislation clarifying that Congress never empowered the FTC to regulate professional associations or to strike down state laws governing the professions (S.1984 and S.2499). The recent favorable vote of the Senate Commerce, Science and Transportation Committee is, we believe, a step in the right direction. Legislation before the House of Representatives that would place a moratorium on FTC activities concerning the professions also has strong support from the medical profession.

In addition, we physicians support proposals that would introduce basic fairness into all FTC proceedings. The measures include (1) providing financial relief from excessive demands for information from the agency, (2) limiting the overly broad subpoena power of the Commission, (3) clarifying what constitutes an "unfair" practice for purposes of the FTC Act, (4) repealing the intervenor program by which the Commission funds entities that it selects to advocate their causes before the agency, and (5) requiring the FTC to bring its actions in federal courts.

To the extent that the FTC may be successful in forcing the medical profession to abandon or minimize responsible self-regulation, the real loser will be the patient whom such self-regulation is intended to protect.

The vital question of whether the FTC will be allowed to continue its self-appointed role of regulator of the professions will soon be decided. Write, wire or phone your senators and representatives. Easier yet, write your name and address across this page, tear out and mail to your legislator, at either:

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For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
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PNEUMOCYSTIS CARINII PNEUMONITIS:
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Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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1. Rubin RH, Swartz MN: *N Engl J Med 303.*426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

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MICHIGAN MEDICINE

September 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 81, No. 40

A
Deal yourself in!
1982 MSMS Annual Scientific Meeting
Nov. 9-10-11
Hyatt Regency Dearborn

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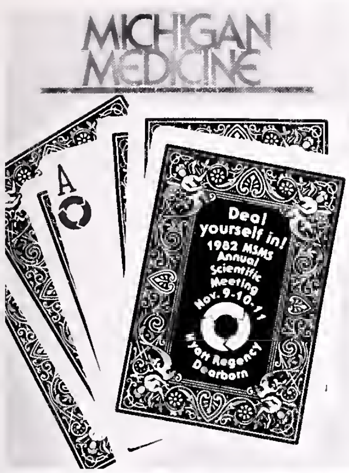
MICHIGAN MEDICINE
Deal yourself in! 1982 MSMS Annual Scientific Meeting Nov. 9-10-11 Hyatt Regency Dearborn

It's your deal, your move, your chance — to learn and earn continuing medical education credits. It's the 1982 MSMS Annual Scientific Meeting Nov. 9-10-11 at the Hyatt Regency Dearborn. And this year's promotional materials — Rubik's Cube, Monopoly, Pac-Man, and on this cover, a card game — emphasize your part in the action. **(Artwork by Joe DuMont.)**

MICHIGAN MEDICINE

Vol. 81, No. 40 September 1982

Special report

486 Family practice, surgery, ophthalmology, radiology, pediatrics, obstetrics and gynecology, psychiatry, dermatology, emergency medicine, pathology, internal medicine, otolaryngology, anesthesiology, allergy — most of the major specialties, as well as the state's medical schools, are planning courses for Michigan physicians at the 1982 MSMS Annual Scientific Meeting Nov. 9-10-11 at the Hyatt Regency Dearborn. All the details and a course registration form appear in this month's special report; Kirk McMurray

Features

501 Register today for the 1982 MSMS Public Affairs/Leadership Conference in Lansing. Keynote speaker is James H. Sammons, MD, AMA executive vice president

504 A senior medical student takes a look at the MSMS organization; Mark R. Traill

508 An alert Hillsdale doctor, with MSMS *Medigram* help, gets his man; Marcia Loader

511 MSMS data flesh out the average member's profile; Deborah Zannoth

516 New feature: Managing your finances; Daniel L. Ludwin

527 Medical office should relax and satisfy most patients; another installment in the "Meeting the challenge of the 80's" series

530 MSMS Judicial Commission opinions

532 Toxic materials in Michigan's environment; Bailus Walker, Jr., PhD

Departments

483 Letters

496 New members

506 MSMS/A; Cheri Calvelo

522 News; Sheri W. Greenhoe

534 Category I courses Meetings

538 Deaths

542 Classified ads

543 Ad index

544 President's page; James H. Tisdel, MD

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Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

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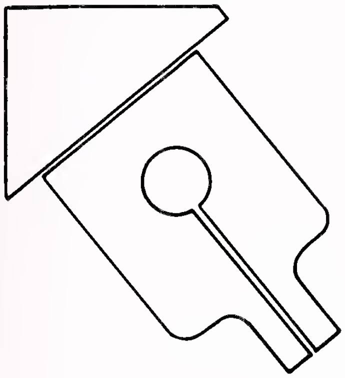
LETTERS



Physicians for Social Responsibility

In your Special Report in *Michigan Medicine*, July 1982, you gave extensive coverage to a meeting at Michigan State University of a group of physicians who have adopted the name "Physicians For Social Responsibility," implying that their view is a socially responsible one. I would like to cast a vote in a somewhat different direction.

I do not feel that avoidance of development of nuclear weapons is a socially responsible position. Indeed, all of recorded history demonstrates that if one nation is stronger than another that it will invariably attack in one form or another. The only exception to this rule may have been the United States, and there is some evidence to the contrary even in the case of the United States.

Most importantly, for a group of self-appointed protectors of society to arrogate unto themselves what constitutes "social responsibility" is an exercise in egomania. I reject their competency to decide for physicians what is socially responsible or irresponsible.

It would be difficult for anyone to argue with the statement that it is best to try to prevent nuclear war, but in essence this group has set up the straw man of those opposing their views essentially promoting nuclear war, which is absurd.

Those of us who believe that the safest posture for this country to assume is that of being the strongest seems to be somewhat more "socially responsible" than urging the United States and Russia and China and any other nuclear country to stop producing nuclear weapons. This bespeaks a naivete which is incomprehensible for any literate human being.

I am disappointed that the views of those opposed to this point of view were not presented.

Clark B. Smith, M.D.
Hillsdale

Fifty-Year Awards

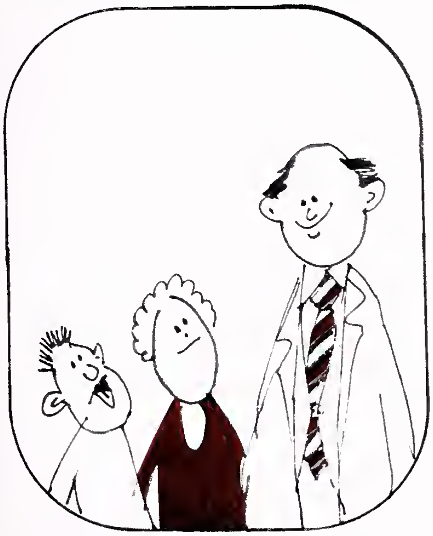
Ever since the nice occasion on May 1 when the 50-year doctors were honored by the state society, I have been intending to write and thank someone for carrying out the affair. The recent arrival of the great group picture with the two candids of me reminded me that I had not responded in any way. And sometime before, I had received a picture of my Henry Ford Hospital colleague and me enjoying a chat over coffee.

The Ren Cen and the Plaza Hotel (now the Westin) are hard to get around in, but with the map and the splendid valet parking arrangements, we did not get lost. We were treated like royalty, from start to finish, from the pinning of the red carnations to the last taste of oysters on the half shell with chilled white wine!

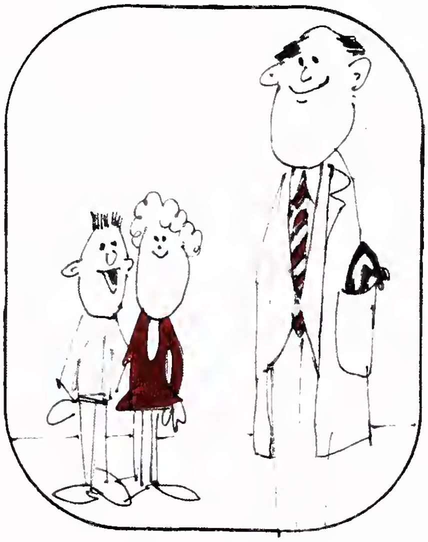
Thanks to you and the great staff.

Conrad R. Lam, MD
Department of Surgery
Henry Ford Hospital
Detroit

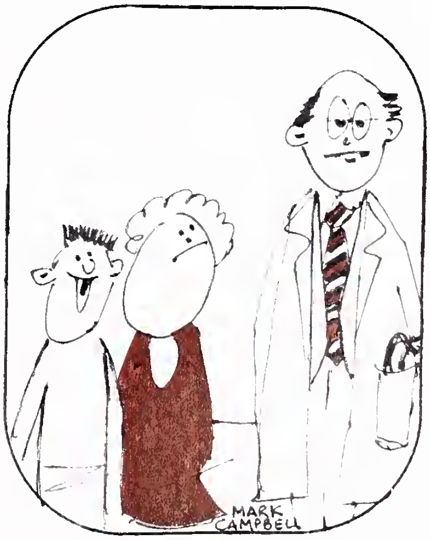
Doctor Quickdraw



Dad . . . Scientific projects help develop our mind . . .



. . . And you are right, that the MSMS Annual Scientific Meeting is Important . . .



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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

> ***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

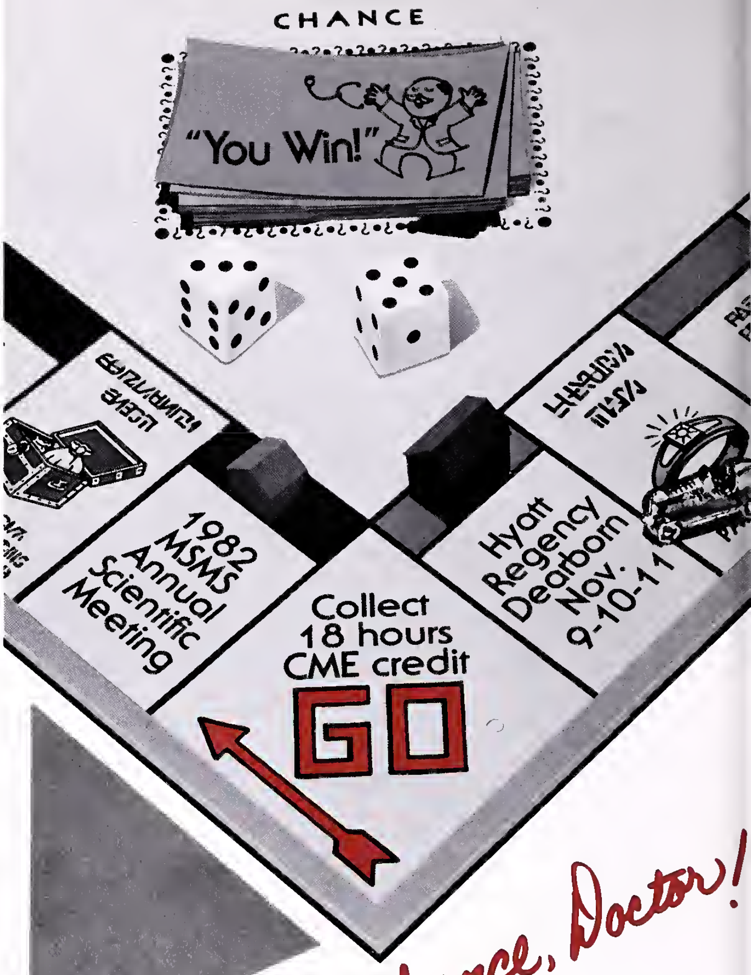
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701

†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110

ROCHE ®

ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701


CHANCE
"You Win!"
1982 MSMS Annual Scientific Meeting
Collect 18 hours CME credit
GO
Hyatt Regency Dearborn Nov. 9-10-11

Here's your chance, Doctor!

To collect 18 hours of CME credit at one, fine, MSMS Sponsored session. The Annual Scientific Meeting November 9-10-11 at the Hyatt Regency Dearborn. Read on through the next eight pages for furthe details about courses, directors, exhibits, hotel, and area attraction that week. And, you may register on page 494. You Win!

Special report

Top-notch course directors planning high quality courses

Tuesday, November 9 Morning Courses

Gregory L. Henry, MD
"Acute Neurological Emergencies"

A problem/decision-oriented course taking difficult neurological concepts and making them simple, to facilitate application in office or ER exams.

John N. Wolfe, MD
"Carcinoma of the Breast"

Carcinoma of the breast is now one of the most important diseases of the female population. All physicians should remain aware of the diagnosis and treatment advances detailed in this course.

Beverly J. Fauman, MD
"Emergency Psychiatry for the General Physician"

This course identifies common psychiatric problems encountered by non-psychiatrists and, via nationally known instructors, provides practical guidelines for initial management of these problems.

Donald Kuiper, MD
Samuel M. McMahon, MD
"Ethical Practice Habits for Healthier Patients"

Demonstrating the relationship between improved practice habits and better patient care, this course seeks to sensitize physicians to the responsibilities of medical licensure and suggests methods for improving prescribing, record-keeping, and reporting procedures.

Douglas Behrendt, MD
Ammon Rosenthal, MD
"Recent Advances in Diagnosis and Management of Cardiovascular Disorders in the Young"

A relatively common problem, congenital heart disease is treatable in most instances. This course explores recent detection techniques and current medical and surgical management methods.

Robert E. M. Ho, MD
"Stroke 1982: An Update in Current Diagnosis and Treatment"

Donald R. Krohn, MD
Ernest Hammel, PhD
"Technology Explosion: Obstetrics/Gynecology"

The OB/GYN specialty has experienced phenomenal technological changes, particularly in the subspecialties of the field. Course attendees will learn what applications these developments have in current clinical practice.

William J. Miller, MD
"Your Patient's Respiratory Tract and His Job"

Tuesday, November 9 Afternoon Courses

George L. Royer, MD
"Anti-Substitution: Dangerous Drug Decisions"

Physicians are not well informed of current drug substitution problems and recent legislative developments. This course presents an overview and update of both therapeutic and generic substitution and allows for specific questions from attendees.

Paul W. Gikas, MD
"Causes and Prevention of Automobile Crash Related Injuries"

Physicians should attend this course to learn about the pathogenesis of the major killer of children and young adults. Information on how to survive a highway crash, convincing arguments for the use of safety belts, and patient education techniques also will be discussed.

Nathan W. Levin, MD
"Common Nephrological Problems"

Through group discussions of case histories, physicians will acquire practical approaches to clinical nephrological problems including hematuria, proteinuria, and azotemia.

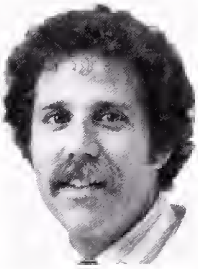
Bacon

Baker

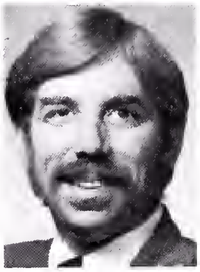
Behrendt

Blumer

Brody


Brown

Bryant


Cotton

Diokno

Ditmars

Ensroth

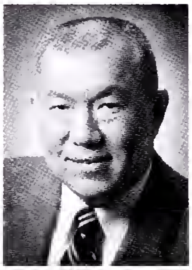
Fauman

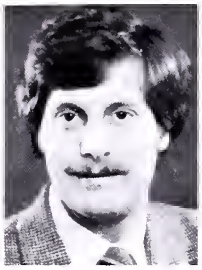
Gelehrter

Gikas

Gurwith

Harrison


Ho


Kemink

Kuiper

LaBan

Levin

Lutes

Mayle

McGillicuddy

Russell F. Smith, MD
"Helping the Healer to Get Help"

People with socially stigmatized conditions (alcoholism, substance abuse, mental illness) do not generally seek help voluntarily. This course provides physicians with techniques which can effectively motivate impaired individuals to get help.

James E. Mayle, MD
"Hepatitis — An Update"

John L. Kemink, MD
"Management of Common Ear and Throat Problems"

Using case pictures of disease processes, this course acquaints physicians with diagnosis and treatment methods for common Otologic diseases and Pediatric Otolarygological problems.

Cornelis Van Nuis, MD
"Multiple Sclerosis: Diagnosis, Management, and Research"

Expressing greater MS optimism than usual and advocating the use of MS as a prototype for other chronic diseases, this course provides a comprehensive treatment plan for maximizing patients' physical, vocational, and emotional well being.

C. Edward Cotton, MD
"Patient Behavior Can Be Changed"

Sumer Verma, MD
"Psychiatry for the General Physician"

Practicing physicians need to develop a greater awareness of psychopathology. This course enables them to do so. It covers a range of topics from differentiation between delirium and dementia to performance of mental status exams.

Wednesday, Nov. 10 Morning Courses

Jack F. Sanders, MD
"Aging — Is It Worth It?"

A multi-specialty, multi-discipline review, this course provides state of the art knowledge about high technology procedures and services available for aging groups — their indications, contraindications, and limitations.

Robert K. Orr, Jr., DO
"Basic Cardiac Life Support"

The "hands on" experience gained in this course enables doctors to become proficient and certified in the techniques of Basic Cardiac Life Support as stipulated by the American Heart Association.

James D. Stroud, MD
"Dermatology for the Non-Dermatologist"

Dermatology should be an important part of every practitioner's daily routine. Better management of diseases and improved diagnosis procedures are primary areas of concentration in this course.

Sean B. Peppard, MD
"Evaluation and Treatment of the Dizzy Patient"

Through lecture, case analysis, and audience questions, this course offers primary care practitioners a rational scheme for evaluation and therapy when treating dizzy patients.

William S. Smith, MD
"Foot Problems: Cradle to Grave"

Problems with feet are very common, however, few physicians possess the knowledge to deal with them capably. This course improves and updates their diagnostic and treatment skills.

Morris Brown, MD
"Management of Mechanical Ventilation"

Physicians attending this course will find ventilator myths removed and will learn the fundamental skills — the how, when, and why — of initiating, managing, and withdrawing ventilatory support.

John P. Papp, MD
"Medical Treatment of Peptic Ulcer Disease — Bleeding and Non-Bleeding"

A current review of an old and common disorder, this course educates physicians on new diagnosis and treatment modalities for Peptic Ulcer Disease.

Marc Gurwith, MD
"New Aspects of Diagnosis and Treatment of Infectious Diseases"

Venereal disease, hepatitis, infectious prononucleosis, and urinary tract, respiratory, and herpes virus infections are discussed in this course. Also included is an antibiotic update.

George E. Bacon, MD
"Pediatric Endocrinology"

A concise review of two major problems encountered in pediatric endocrinology: insulin-dependent diabetes mellitus (management), and short stature (screening evaluation and treatment), comprises the major focus of this course.

Beverly J. Fauman, MD
"Victims of Violence"

To provide good care and to comply with mandatory reporting laws, physicians must develop an increased awareness of the clues which suggest someone has been a victim of violence. This course offers them a significant opportunity to do so.

Wednesday, Nov. 10 Afternoon Courses

Murray R. O'Neil, MD
"Allergy and Asthma: Diagnosis and Management"

This course offers an allergy update, asthmatic patient work-up procedures, and current asthma treatment methods.

John Wagner, MD
"Basic Aspects of Athletic Injuries and Treatment Approaches in Sports Medicine"

Earl J. Rudner, MD
"Dermatological Aspects of Sports Medicine"

Attending physicians gain knowledge of basic exercise physiology, nutrition, and techniques of recognition for sports-associated skin problems.

Myron M. LaBan, MD
"Diagnosis and Conservative Treatment of Neck and Arm Pain"

Ninety five percent of neck and shoulder pain complaints are amendable to medical treatment. This course offers physicians information on current recognition, diagnosis, and treatment methods.

Byron B. Lutes, MD
"Diverticular Disease — Old and New Concepts"

Sean B. Peppard, MD
"Medical and Surgical Management of Inflammatory Sinus Disease"

This course provides practitioners with a basis for evaluating obstructive and drainage problems of the nose and sinuses.

Thomas D. Gelehrter, MD
"Medical Genetics for the Practicing Physician"

An increasingly sophisticated patient population is coming to expect genetic counseling as standard medical care. This course provides physicians with techniques allowing application of genetic principles in selected patient families.

Samuel M. McMahon, MD
"Pulmonary Function Studies and Arterial Blood Gases"

Using a workshop format, this course helps physicians learn to interpret pulmonary function and arterial blood gases studies more effectively.

Ananias C. Diokno, MD
"Urinary Incontinence — Evaluation and Treatment"

Course attendees learn the mechanisms of urinary continence and incontinence, evaluation tests, treatment drugs, treatment options, and surgical approaches.

Thursday, Nov. 11 Morning Courses

Robert K. Orr, DO
"Basic Cardiac Life Support"

(See listing for Wednesday Morning)

Donald Ditmars, MD
"Congenital Anomalies in Plastic Surgery: Basic Concepts"

Basic understanding of congenital anomalies are discussed in this course with an emphasis on multispecialty problems which interface with plastic surgery.

Dietrick P. Blumer, MD
"Depression: Modern Concepts in Recognition and Treatment"

George L. Royer, MD
"Diabetes — Current Concepts and Update"

A current review of diabetes presented by experts with ample time reserved for discussion and clarification.

Frederick W. Bryant, MD
"Endurine Disease and the Eye"

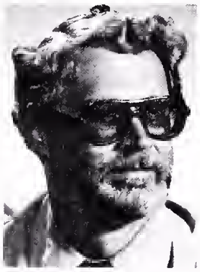
McMahon

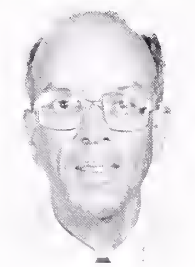
Miller

O'Neil

Papp

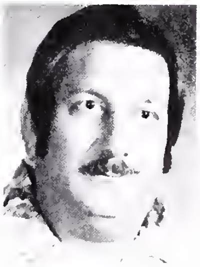
Peppard

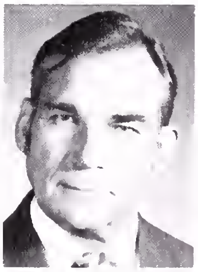

Royer


Rudner

Sanders

Slovis


Smith


Smith

Stroud

Stryker

Taber

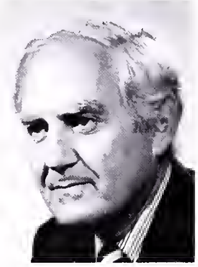
Thrall

Tourkow

Turcotte

Verma

Wagner


Walt

Weiss

Wolfe

Beverly J. Fauman, MD
Mary V. Ensroth, MSW
"Ethnicity and Medical Practice: Diagnosis, Treatment Planning, and Treatment Compliance"

Ethnicity is seldom addressed in these terms — its effects on family therapy and the provision of patient medical care. Designed to benefit all physicians, the course exposes them to ideas about the characteristics of various ethnic groups and cultural influences in family dynamics.

Rodman T. Taber, MD
Robert W. Harrison, MD
"Management of Chest Injuries"

This course offers physicians updated information on emergency and long term management of intrathoracic trauma.

Alexander J. Walt, MD
"Problems Faced by Surgeons in the Intensive Care Unit Postoperatively"

Physicians need to feel secure in the rapidly broadening field of critical care. Attendees gain knowledge of modern monitoring methods, results interpretation, and application of the data available to them.

Shan R. Baker, MD
"What the General Practitioner Needs to Know About Head and Neck Cancer"

Course information includes differential diagnosis of neck masses and other skin cancers, surgery for facial skin cancer, which skin cancers require specialist attention, and the importance of early diagnosis and treatment.

Jeremiah G. Turcotte, MD
"Workshop on Vascular Disease: Diagnosis and Management for the Generalist and Specialist"

Thursday, Nov. 11 Afternoon Courses

James E. McGillicuddy, MD
"Acute and Chronic Back Pain"

This course provides an indepth look at low back pain from both physical and psychological perspectives with heavy emphasis on clinical presentation. Attendees receive information on differential diagnosis and appropriate evaluation and treatment methods.

Frederick W. Bryant, MD
"The Advancing Technology Parade in Ophthalmology"

Howard Brody, MD
"Clinical Determination of Mental Capacity"

Donald Ditmars, MD
"Congenital Anomalies in Plastic Surgery: Specific Reconstructive Procedures"

This course discusses in detail specific reconstructive procedures for the correction of congenital anomalies of the ear, eyelids, and face.

Joseph J. Weiss, MD
"Gout, Pseudogout, and Other Crystalline Deposition Syndromes"

The standard of practice concerning these conditions is changing. Physicians, both for knowledge and protection, need to be aware of these changes. This course brings them up to date.

James H. Thrall, MD
"Nuclear Cardiology: Uses in Clinical Practice"

With a major emphasis on clinical indication, three important radioisotopic procedures are introduced which 1) measure ventricular function, 2) detect acute myocardial infarction, and 3) detect myocardial ischemia.

Thomas L. Slovis, MD
"Pediatric Ultrasound — How You Can Effectively Use It In Practice"

By understanding the capabilities of ultrasonic modality as presented in this course, the clinician can expect to use the modality producing the least radiation and effectively answer his or her diagnostic queries.

Joan C. Stryker, MD
"Born Before Their Time: Managing Prematurity"

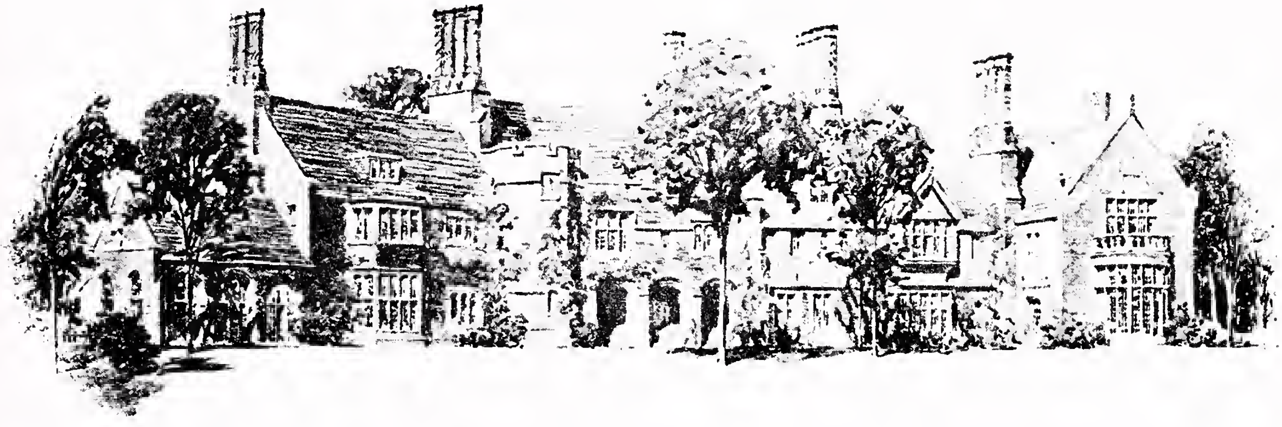
There are new concepts concerning approach to delivery and treatment of premature babies which this course addresses. Causes and preventive measures also are discussed.

Lawrence P. Tourkow, MD
"Psychotherapy by the Primary Physician — Psychoanalyst Team"

Detroit area has many attractions

Physicians at Scientific Meeting may tour, dine at Meadow Brook Hall

By Kirk McMurray
East Lansing



The approaching visitor sees the mansion in the distance, casting a warm glow from the stained and leaded glass windows of its 100 rooms to the carefully landscaped yard below. That's Meadow Brook Hall on a crisp November evening.

Built between 1926 and 1929 at a cost of over $4 million, Meadow Brook Hall was home to Alfred and Matilda Dodge Wilson. Reminiscent of England's Tudor and Elizabethan manors, the house displays exquisite craftsmanship from its wood and stone carvings, sculptured ceilings, and fine paneling, to each specially designed ceramic tile and porcelain doorknob.

At the time of this writing, Mr. McMurray was an intern with the MSMS departments of communications and socio-economics. He is a graduate student at the University of Michigan, where his field is marketing.

Splendor further typifies the home's furnishings, 85 percent of which are original. Antiques from 17th century France, tapestries, a pipe organ, first edition books, silk covered walls, and irreplaceable collections of jade, paintings, china, and crystal are among the treasures of Meadow Brook.

The opportunity to tour and dine at this magnificent National Historic Site is available to all preregistering Annual Scientific Meeting participants and their guests at reasonable cost. The tour is scheduled to begin at 7:30 PM on Wednesday, November 10, with dinner in the estate's dining room to follow at 8:45.

Complete information about this evening will be detailed in a letter accompanying the ASM registration confirmation packet. A reservation form will be included.

Of course, Meadow Brook is only one of many special places to visit in the Detroit metropolitan area. MSMS members and their spouses may wish to include visits to these prime locations in their Annual Scientific Meeting itinerary in November. This article is designed to help in the planning.

The Ren Cen and the Fisher Theatre are perennial favorites, of course, and sports fans may want to attend a Piston or Red Wing game while in town. But don't discount the lesser known attractions.

Detroit's Cultural Center is magnificent. From the convenient parking garage beneath the Art Institute (enter at Woodward and Farnsworth) visitors to the area have easy access to the Institute, the Detroit Public Library, the Historical Museum, the Science Center, and the Children's Museum.

The Detroit Institute of Arts is the fifth largest art museum in the country and includes some of the world's foremost collections of American, European, African, Indian, ancient, and graphic art. Many of its more than 100 galleries are as interesting for their architecture as for the works of Rodin, Renoir, Picasso, van Gogh, and Matisse they house.

The Institute's Rivera Court is the most spectacular of its galleries with its murals depicting the interrelationships of man, industry, and labor. Free hour-long introductory tours of museum collections are available daily, beginning at 12:15 PM. And for rest, conversation, and food, the Kresge Court Cafe offers a pleasant environment from 11 AM until 4 PM.

Across the street from the Art Institute stands the architecturally award-winning Detroit Public Library. Home of the world's largest automotive history collection, the library also contains some two million volumes, and a Detroit history mural in the second floor reference room.

The Detroit Historical Museum offers the opportunity to explore the city's history — from its founding by Cadillac to last summer's Grand Prix race. Special features in early November will include a nostalgic look at circuses, a small puppets exhibit designed to coincide with a like exhibition at the Art Institute, a photo essay of Detroit, and an exhibit of historic sights in the Black community.

A spectacular domed-screen theatre is the main attraction at the Science Center. Elsewhere in the museum are space exhibits and 50 hands-on science experiments.

Hands-on is the key phrase for describing the Children's Museum, too, as visitors are encouraged to "please touch." The planetarium, crafts room, doll house display, and exhibits featuring cultures from around the world interest adults and children alike.

After the Cultural Center visit the Eastern Market to get a true taste of Detroit. Each morning (beginning at 5 AM!) farmers bring their fresh produce, meat, and flowers to the decorative and colorful buildings which house over 100 retail and wholesale stalls, shops, and restaurants.

And to the north, the Cranbrook Academy's Art Museum and Institute of Science are open daily on the Cranbrook campus in Bloomfield Hills. Along with the permanent Cranbrook Collection, the Art Museum displays continually changing exhibitions. The Science Institute has a natural history museum which traces the history of the earth, "participation encouraged" displays in the physics hall, and a mineral collection that ranks as the country's finest.

And finally, practically in the Hyatt's backyard, Dearborn has Greenfield Village and the Henry Ford Museum. Artifacts, crafts, homes, and buildings from America's past are grouped here and preserved. In fall, fresh pressed cider and a carpet of colorful leaves make the Village all the more appealing. The museum, fascinating in every season, will have a special exhibit in November entitled "The Worker's World: The 19th Century Industrial Village and the Company Town."

At-a-Glance Schedule of ASM Special Events

Tuesday, November 9

5 PM **"Meet the Professor"**
An opportunity to meet informally in the exhibit hall with course instructors. Beer will be served.

Evening **Exhibits open until 8 PM**

Reception and Dinner
Sponsored by the MSMS Program to Assist Impaired Physicians, the American Medical Society of Alcoholism, and Michigan International Doctors in AA.

Wednesday, November 10

5 PM **"Meet the Professor"**
(see above)

Evening **Reception and dinner**
The Michigan Society of Colon and Rectal Surgeons.

Reception and dinner
American Medical Women's Association.

Meeting and dinner
Michigan Society of General Surgeons.

Reception
Wayne State University Medical Alumni.

Reception and dinner
Michigan Otolaryngological Society.

Meeting and Dinner
Michigan Urological Society

Thursday, November 11

Evening **Meeting, reception and dinner**
Michigan Ophthalmalogical Society.

Exhibitors offer education, products

1982
MSMS
Annual Scientific
Meeting
November
9-10-11
Hyatt Regency
Dearborn
Your CME
Solution

Exhibition space at the MSMS Annual Scientific Meeting has been reserved by 65 companies and organizations eager to display the newest medicine-related products and services.

The majority of the exhibitors are commercial entities offering support services such as insurance coverage and laboratory facilities or products ranging from computer and telephone equipment to encyclopaedias and pharmaceuticals. In all cases, featured products are state of the art — whether updated versions of accepted product types or the result of recent technological innovation.

Dart Medical Inc., for example, offers a revolutionary service which allows physicians to closely monitor the heart activity of patients not in the hospital. Consisting of a small electronic monitor and an extensive communications network, the system allows patients to call a toll-free number at any time and transmit their EKG to trained medical observers.

Other organizations offer no products, but use exhibit space to dispense information about their activities. One such organization is Physicians for Social Responsibility. A national group, these doctors are committed to efforts aimed at prevention of a nuclear holocaust.

The complete list of 1982 ASM exhibitors follows. MSMS is pleased that they have chosen to participate this year.

Exhibitors

Pharmaceuticals

Adria
Ayerst
Bristol
Dista
Ferndale
Glaxo
Kremers-Urban
Eli Lilly
Merck Sharp & Dohme
Merrell Dow
Parke Davis
Pfizer
Reed & Carnick
Smith Kline & French
Syntex
Upjohn
USV

Clinical Laboratories

Advance Medical & Research
Continental Bio-Clinical Labs
Dearborn Clinical Lab
Metapath Inc.
Oakland Diagnostic Labs
Quality Clinical Labs
Smith Kline & French Labs

Computers/Computer Services

American Software Company
Comedco
Datamed Corporation
Michigan Medical Service
Omni American
Paradata Systems
Rollins Medical/Dental Systems
Systemedics Associates
3 PM
United Medical

In-Office Support

City Xray
Firestone X-Ray
The Helm Company
Light Com
Michigan Bell
Troy Biologicals
Vascular Diagnostic Instruments

Patient Home Care

Binsons Hospital Supplies
Dart Medical
Gerber Products
Healthways
Mead Johnson Nutritional Division
White and White

Educational Resources

Encyclopaedia Britannica
W. B. Saunders

Protection

Blue Cross/Blue Shield
First Heritage Corporation
The Medical Protective Co.
MPMLC
Physicians Insurance Company of Michigan
Stratton Cheeseman

Career Alternatives

United Medical
U. S. Air Force
U. S. Army
U. S. Navy

Other Exhibitors

Henry Ford Hospital, Maplegrove Alcoholism Treatment Center
McCullagh Leasing (Automobile Leasing)
Michigan Ophthalmological Society
National Health Corporation of Michigan (Health Hazard Appraisal)
Physicians for Social Responsibility
SKF Market Research

PLEASE SEND ENTIRE PAGE WITH CHECK

1982 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration form for Category I CME Courses

***All courses are approved for AAFP Prescribed Credit *EXCEPT* those marked with an asterisk.**

TUESDAY MORNING, NOV. 9

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Acute Neurological Emergencies
____ Basic Cardiac Life Support
____ Carcinoma of the Breast
____ Emergency Psychiatry for the General Physician
____ Ethical Practice Habits for Healthier Patients
____ Recent Advances in Diagnosis and Management of Cardiovascular Disorders in the Young
____ Stroke 1982: An Update in Current Diagnosis and Treatment
____ Technology Explosion in Obstetrics/Gynecology
____ Your Patient's Respiratory Tract and His Job

TUESDAY AFTERNOON, NOV. 9

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Anti-Substitution: Dangerous Drug Decisions
____ Causes and Prevention of Automobile Crash Related Injuries
____ Common Nephrological Problems
____ Helping the Healer to Get Help
____ Hepatitis — An Update
____ Management of Common Ear and Throat Problems
____ Multiple Sclerosis: Diagnosis, Management, and Research
____ Patient Behavior Can Be Changed
____ Psychiatry for the General Physician

The half-day courses will provide three hours of Category I credit toward the state relicensure requirements and the AMA Physician's Recognition Award.

Please check the courses you wish to attend. In each case, *please indicate a second choice* should the first choice already be filled. Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 10/18/82 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, 313/593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

WEDNESDAY MORNING, NOV. 10

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Aging — Is It Worth It?
____ Basic Cardiac Life Support
____ Dermatology for the Non-Dermatologist
____ Evaluation and Treatment of the Dizzy Patient
____ Foot Problems: Cradle to Grave
____ Medical Treatment of Peptic Ulcer Disease — Bleeding and Non-Bleeding
____ New Aspects of Diagnosis and Treatment of Infectious Diseases
____ Pediatric Endocrinology
*____ Simplified Management of Mechanical Ventilation
____ Victims of Violence

WEDNESDAY AFTERNOON, NOV. 10

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Allergy and Asthma: Diagnosis and Management
____ Basic Aspects of Athletic Injuries and Treatment Approaches in Sports Medicine
____ Dermatological Aspects of Sports Medicine
____ Diagnosis and Conservative Treatment of Neck and Arm Pain
____ Diverticular Disease — Old and New Concepts
____ Medical and Surgical Aspects of Inflammatory Sinus Disease
____ Medical Genetics for the Practicing Physician
____ Pulmonary Function Studies and Arterial Blood Gases
*____ Urinary Incontinence — Evaluation and Treatment

THURSDAY MORNING, NOV. 11

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

*____ Congenital Anomalies in Plastic Surgery: Basic Concepts
____ Depression: Modern Concepts in Recognition and Treatment
____ Diabetes — Current Concepts and Update
____ Endocrine Disease and the Eye
____ Ethnicity and Medical Practice: Diagnosis, Treatment & Patient Compliance
*____ Management of Chest Trauma
____ Problems Faced by Surgeons in the Intensive Care Unit Postoperatively
____ What the General Practitioner Needs to Know About Head and Neck Cancer
____ Workshop on Vascular Disease: Diagnosis and Management for the Generalist and Specialist

THURSDAY AFTERNOON, NOV. 11

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Acute and Chronic Back Pain
____ Born Before Their Time: Managing Prematurity
*____ Congenital Anomalies in Plastic Surgery: Specific Reconstruction Procedures
____ Gout, Pseudogout and other Crystalline Deposition Syndromes
____ Medical Ethics: Clinical Determination of Mental Capacity
____ Nuclear Cardiology: Uses in Clinical Practice
____ Pediatric Ultrasound — How You Can Effectively Use it in Practice
____ Psychotherapy by the Primary Physician Psychoanalyst Team
*____ The Current Technological Parade in Management of Eye Diseases

- -

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia, may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Krishan L. Aggarwal, MD **P/GP**
29800 Middlebelt
Farmington Hills, 48018

Farooq P. Agha, MD **R**
1405 E. Ann St.
Ann Arbor, 48109

Bruce H. Baker, MD **AN**
153 Lafayette Ave., SE
Grand Rapids, 49503

Jeffrey D. Band, MD **IM/ID**
4707 St. Antoine Blvd.
Detroit 48201

Jay M. Berman, MD **OBG**
21421 Winchester
Southfield, 48076

Sunil Bhatia, MD **IM**
740 S. Emerick St.
Ypsilanti, 48197

Thomas C. Burk, MD **EM**
1605 Hotchkiss Rd.
Bay City, 48706

N. B. Chari, MD **GS**
29900 Harper Ave.
St. Clair Shores, 48082

Yasmin R. Engineer, MD **OBG**
19401 Hubbard Dr.
Dearborn, 48126

Jay H. Eppinga, MD **ORS**
199 Long Rapids Rd.
Alpena, 49707

Bernard S. Greenberg, MD **OBG**
31182 Claymore
Farmington Hills, 48018

Walter J. Gruber, MD **IM**
2707 Ashman
Midland, 48640

Russell E. Holmes, MD **GPM/FP**
405 University Dr.
East Lansing, 48823

Richard J. Honer, MD **GS**
4101 Oak Park, SE #24
Grand Rapids, 49508

Cheryl Ann Huckins, MD **IM**
387 Adams
Plymouth, 48170

Mostafa A. H. Ibrahim, MD **IM/GE**
Henry Ford Hospital
Detroit, 48202

Curtin G. Kelley, MD **OPH**
1795 Farmbrook Dr.
Troy, 48098

John W. Kitzmiller, MD **CVS**
3535 W. 13 Mile Rd. #206
Royal Oak, 48072

Mark D. Kolins, MD **CLP/PTH**
637 Lincoln Rd.
Grosse Pte., 48230

Mark P. Koniuch, MD **ORS**
Henry Ford Hospital
Detroit, 48202

Linh The Le, MD **GP**
456 Glenwood, S.E.
Grand Rapids, 48506

Laurie G. McKeown **(student)**
1140 Nielsen Ct. #6
Ann Arbor, 48105

Mark R. McMurray **(student)**
3913 S. Pennsylvania
Lansing, 48910

Daryl R. Melvin, MD **IM**
405 W. Greenlawn #200
Lansing, 48910

Daniel B. Michael, MD **FP**
893 St. Clair
Grosse Pte., 48230

Robert S. Morden, MD **PDS/GS**
506 Beaumont Medical Bldg.
Royal Oak, 48072

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245 State St., S.E.
Grand Rapids, 49503

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1248 Somerset Close
East Lansing, 48823

Sudhir Ranjan, MD **AN**
Henry Ford Hospital
Detroit, 48202

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W-706 Owen
East Lansing, 48825

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East Lansing, 48823

Khalil K. Shirazi, MD **R**
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Ann Arbor, 48109

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17212 Flint St.
Melvindale, 48122

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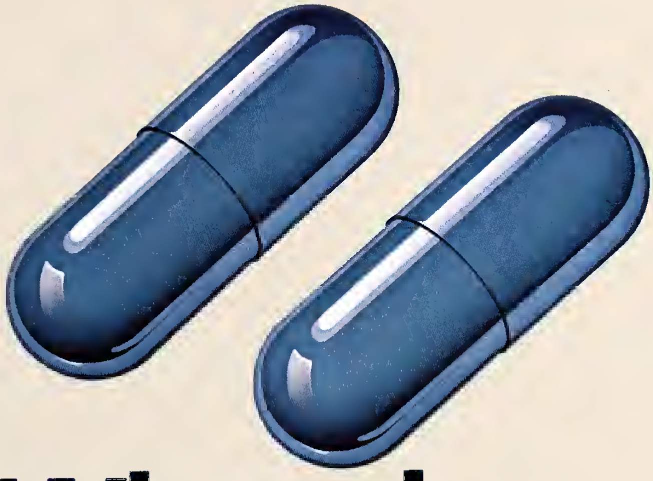

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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae)* and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae,* staphylococci, and *S. pneumoniae;* Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli, P. mirabilis, Klebsiella* species, and enterococci *(S. faecalis).*

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS; *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro.* Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy: Teratogenic Effects/Impairment of Fertility — Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

(continued on next page)

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(continued)

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Blood — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structures infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h.).

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae:* 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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Registrations already coming in for MSMS Leadership Conference

Politics, economics, professional liability and public health will share billing at the 1982 MSMS Public Affairs/Leadership Conference Oct. 28 at Long's Convention Center, Lansing.

The popular all-day event has been drawing Michigan physicians' registrations since the first week of notice of the event during the summer. Its combination of inside information, predictions of future trends and sharp-edged dialogue each year draws larger crowds of MSMS members, auxilians and guests.

Chairman of this year's event is Fred E. Patterson, MD, Ann Arbor radiologist. He has planned sessions on the Michigan Doctors Political Action Committee, 1982 elections, effects of economic trends and market forced on medical practices, the AMA's priorities, the Michigan professional liability insurance climate and the state's public health.

Keynote speaker is James H. Sammons, MD, executive vice president of the AMA. The full program and a registration form appears on the flip side of this page. For details, contact Kevin Kelly or William Madigan at MSMS headquarters.

Following are biographical sketches of the conference's major speakers:

James H. Sammons, MD, is executive vice president, American Medical Association, a position he has held for eight years. He has led the AMA through its legal battles with the FTC, through major reorganization and development of national health policy. Doctor Sammons is a 54-year-old family physician from Texas. He is a member of the Institute of Medicine, U.S. Chamber of Commerce Special Committee on Health Care Needs and the National Conference on Medical Education Planning Conference.

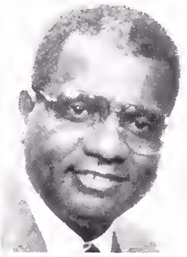
Prior to the Public Affairs/Leadership Conference this year, executive directors and secretaries of county medical societies are invited to a 3 to 9 PM session Oct. 27 in Lansing. Hosted by MSMS, the executives' meetings will provide them a chance to share their concerns with MSMS staff and learn about MSMS projects. Details of that meeting are available from Wayne Burmeister at MSMS headquarters.

Nancy Baerwaldt was appointed Michigan's Insurance Commissioner by Governor Milliken Aug. 27, 1980, and previously served as deputy director of the Michigan Department of Commerce. Prior to that, she was director of research and evaluation for the Michigan Department of labor and a fiscal analyst with the departments of Management and Budget and Social Services.

Tom Greene is WDIV Lansing Bureau Chief and senior political reporter. Greene joined WDIV in September, 1980, after 13 years with WJBK-TV as that station's Lansing Bureau Chief.

Greene is the senior political reporter of the Capital Correspondents Association and the Dean of the Michigan Press Corps. He is the only TV reporter in Michigan to have covered every national political convention since 1968. He has won nearly every major political journalistic award in Michigan.

Paul J. Feldstein, PhD, is professor in the program of hospital administration, School of Public Health and Department of Economics, The University of Michigan, where he has been on the faculty since 1964. Doctor Feldstein previously was director, Division of Research, American Hospital Association. He has served as a consultant with the World Health Organization, Bureau of the Budget and Social Security Administration, and consulted with MSMS during the recent FTC case in Washington.



Bailus Walker, PhD, an environmental health scientist, has been director, Michigan Department of Public Health since August, 1981. Prior to that he was director, Occupational Health Standards Directorate for the Occupational Safety and Health Administration, U.S. Department of Labor.

Earlier, Doctor Walker was environmental health scientist and administrator, Environmental Health Services, District of Columbia.

Register here!

AMA chief executive, James Sammons, MD, to keynote MSMS Public Affairs Conference Oct. 28

James H. Sammons, MD, executive vice president, American Medical Association, will head a distinguished roster of speakers for the 1982 MSMS Annual Public Affairs/Leadership Conference. The popular event for state and county medical society leaders is scheduled Oct. 28 at Long's Convention Center, Lansing.

Doctor Sammons will have the final morning slot on the program, presenting, at 11 a.m., an "AMA Briefing — Medicine's Priorities." Doctor Sammons has been AMA executive vice president for eight years, and has led the AMA through its legal battles with the FTC, major AMA reorganization and development of national health policy. U.S. News and World Report touts Doctor Sammons as the "second most influential person involved in health policy decisions" today.

The MSMS Public Affairs/Leadership Conference grows in popularity each year. Interested physicians should check the program below and register early, to guarantee their place.

Program

8:30 REGISTRATION

9:00 CALL TO ORDER — Fred E. Patterson, MD, chairman, MSMS Public Affairs Leadership Conference

9:05 MD POLITICAL ACTION — Thomas C. Payne, MD, chairman, Michigan Doctors Political Action Committee

9:25 "ELECTION '82 — POLITICAL PROGNOSTICATIONS" — Tom Greene, political analyst, WDIV-TV, Detroit

10:15 "YOUR PRACTICE AND THE CHANGING WORLD OF MEDICAL ECONOMICS" — Paul Feldstein, PhD, economist, University of Michigan

11:00 "AMA BRIEFING — MEDICINE'S PRIORITIES" — James H. Sammons, MD, executive vice president, American Medical Association

12:00 LUNCHEON

1:00 "PROFESSIONAL LIABILITY AND ARBITRATION — THE MICHIGAN INSURANCE CLIMATE" — Nancy A. Baerwaldt, Commissioner of Insurance, Michigan Insurance Bureau

1:45 "MICHIGAN PUBLIC HEALTH PERSPECTIVES" — Bailus Walker, Jr., Ph.D., director, Michigan Department of Public Health

2:30 BREAK

2:45 PANEL PRESENTATION — "MARKET FORCES AFFECTING HOSPITALS AND PHYSICIANS" — Donald K. Crandall, MD, moderator, president-elect, Michigan State Medical Society; Arthur Knueppel, president, W.A. Foote Memorial Hospital; William Van Faasen, vice president, health care policy development, Blue Cross and Blue Shield of Michigan; Jack Ryan, MD, president, Detroit/Macomb Hospital Association; Whitney Spaulding, director of planning, Sisters of Mercy Health Care Corporation.

4:00 OVERVIEW — Donald K. Crandall, MD, MSMS president-elect

1982 Public Affairs/Leadership Conference
Michigan State Medical Society
P.O. Box 950
East Lansing, Michigan 48823

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For more information:
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or Kevin Kelly
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AMA

My view after seeing MSMS at work: physician community must take strong role

By Mark R. Traill
Detroit

During the month of July I had the opportunity to spend time studying on an elective basis at MSMS headquarters. I felt I needed a break from clinical training to get an overview of organized medicine and the health care decision-making system. I wanted to gather enough information to make a prediction about what might be store for a doctor graduating in 1983.

The staff at MSMS was very helpful in supplying me with information, opinions and meetings to attend. I was somewhat familiar with the catch words that make the press: cost containment, surplus of physicians, and over-utilization.

However, it was not until my visit that I was able to see the implications of these words and who was behind the enactment of these implications. The most significant impressions came from observing various meetings and people. I had read articles and papers discussing health care issues; but as the saying goes, "a picture is worth a thousand words."

One afternoon I attended a meeting of the Health Care Economics Coalition. Members of this group were a major force in pushing through hospital bed reductions and have set a national model for how big industry, labor, third party insurers and providers can organize to help direct health care issues. The topic of this particular meeting wasn't as interesting as seeing how each member announced and defended his or her own viewpoint. Especially memorable was the way the UAW representative nearly popped out of his chair when the topic of policy benefit reductions for UAW members covered by Blue Cross and Blue Shield of Michigan was brought up.

An eye-opening morning was spent with John Anthony, manager of the MSMS Physician Service Group, Inc., on a consult for a group practice that was interested in the benefits of installing an in-house computer to handle records and billing.

This was my first opportunity to analyze the everyday workings of an office and to see in exact figures how the cash flow was divided. From the interest shown by the group in the consult and the comments from Mr. Anthony I got a feel for the private business aspect of medical practice.

Another morning I was at the House Appropriations Subcommittee Public Hearing on Medicaid Fraud and Abuse. I was given a good feeling of the frustration that the State and local medical societies feel over not being able to enforce standards upon those physicians in the state that abuse the Medicaid system. This feeling was eloquently summed up by the representative from the attorney general's office when he described local judges as "swift as a box of rocks."

Another Medicaid meeting I attended was a subcommittee discussion on the guidelines for the use of a closed formulary for the Medicaid patient. At the meeting, committee members sat at a large table literally surrounded by a ring of drug company representatives who sat statue-like listening to every word. Their faces, however, did show expression when the meeting began to stumble, and a sense of relaxation could be felt across the room.

The largest meeting I attended was the bi-monthly session of the Statewide Health Coordinating Council. I had seen the state health plan for 1983-87 and was quite interested in seeing the group that had put together such a massive document with all its unknown potential. The interesting element here was the diversity in the backgrounds of the representatives present and the fact that collectively the providers present were not the majority.

The most positive observation of my stay was at a press conference at MSMS announcing the formation of the Michigan Coalition for Safety Belt Use. Robert D. Burton, MD, Grand Rapids, MSMS vice speaker, was in charge.

The conference was well attended and included Representative David Hollister and Secretary of State Richard Austin. It was easy to see the pride that Doctor Burton felt being the physicians' representative, and it was impressive to see the favorable response of the press to the physicians' point of view. Indeed, the evening news highlighted Doctor Burton's comments above all others.

My last observation is the one I would like readers to remember. My opportunity to observe the makers and shakers of health policy in action showed that if the physician community doesn't take a strong role in decision-making, there are lots of other groups around that will do it instead.

The Michigan physician's future is going to hold increasing economic considerations and more attempts at influencing health care and the practice of medicine from outside. Physicians will have to exert their influence to be major policy makers for the changes destined to come.

Mark R. Traill is a senior medical student at Wayne State University and a student member of MSMS. In the future he plans to specialize in family practice. He arranged his visit with MSMS through the Department of Community Medicine at WSU.

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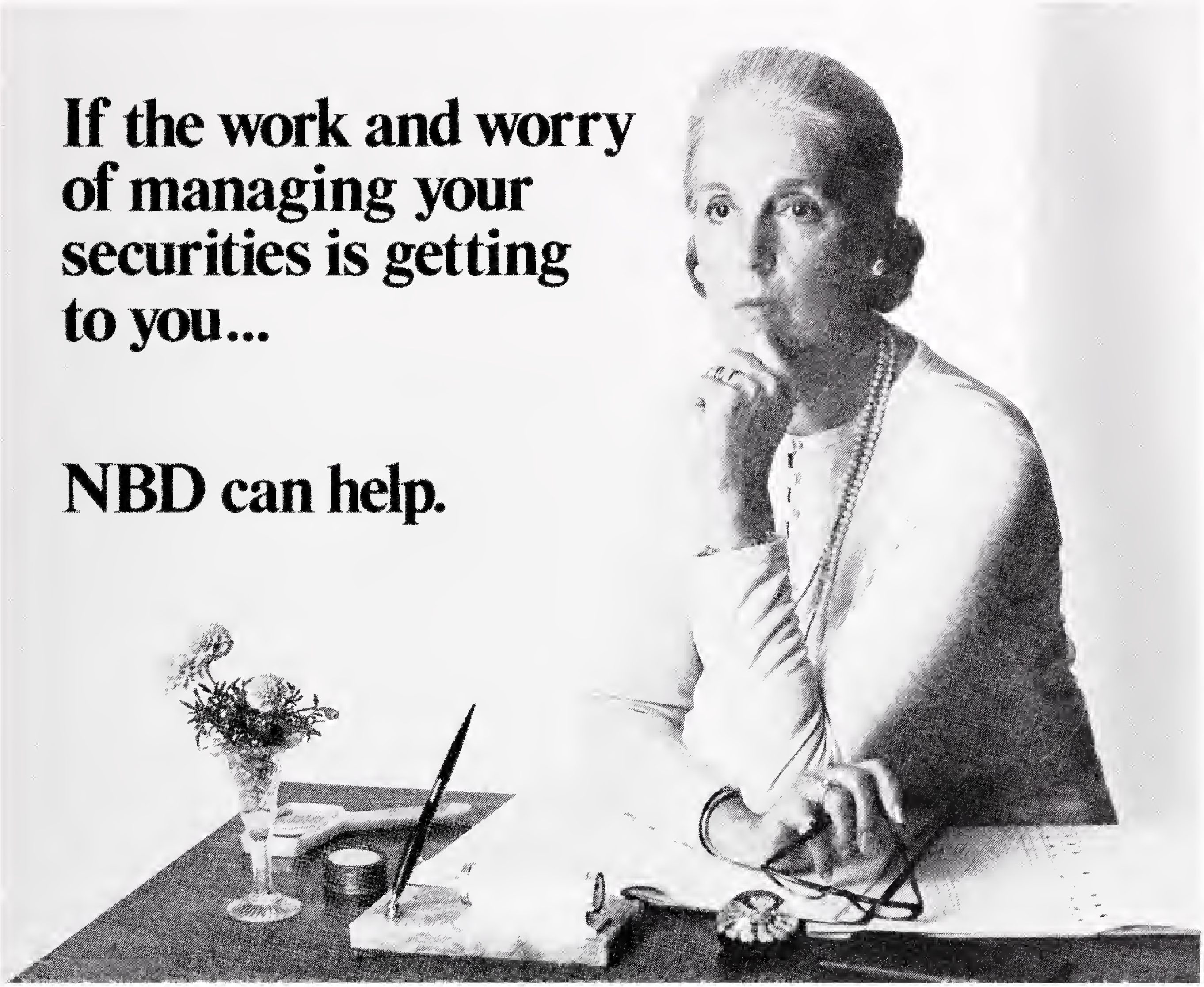

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Walking With Cheri

by Cheri Calvelo Jackson

A daily exercise program should begin with a warm-up, follow with a period of optimal workout and end with a cool-down period.

By following such a regimen, we keep our bodies in good shape in the most healthy manner. I am challenging MSMS auxilians and members to follow such a regimen with me.

In my inaugural address, I invited MSMS Auxiliary members to "Walk With Cheri," encouraging them to become involved in a regular program of exercise if they were not already. By "regular" I mean 30 minutes of exercise three to five days a week.

I have been a walker for five years, averaging four miles a day. I have found it to be great for mind, body, and spirit.

We, as Auxilians, owe it to ourselves, our families and our communities to set examples of good health practices throughout our daily activities. We need to be models for others by demonstrating good nutrition, regular exercise, weight control, alcohol use in moderation, by managing stress, and by not smoking. Not only is it important that we are good examples, but also by being such, we will feel better and live longer.

"Make Good Health a Habit" is the new slogan of the AMA Auxiliary this year as it continues and expands its "Shape Up for Life Campaign." This campaign encourages us, and invites us to communicate to others good health habits, good nutrition, exercise, and stress management all of our years.

Mrs. Calvelo is president of the MSMS Auxiliary.

I also invited Auxilians to "Walk With Cheri" in the sense of working together as a team. Once again I was following the idea of an exercise program of warm-up, optimal workout, and cool-down. This summer, there have been meetings as we set goals and objectives for the year. This was our warm-up.

Now in September, we being to work together to reach our goals. We hope to communicate to all Michigan Auxilians through our newsletter the "Auxilium." There will be five workshops in different areas of the State for all members to participate in. Also there will be visits to individual counties.

Then AMPAC and MDPAC will be working in cooperation on a pilot project here in Michigan, sponsoring a Fall Political Education Workshop on September 20. We also are happy to be participating in the MSMS Public Affairs Leadership Conference on October 28.

MSMS Auxiliary members are excited to be involved with nine MSMS committees. There can be better communication if we work in cooperation. MSMS and the Auxiliary working together as a coalition can be a powerhouse. We need to work as a team.

Following the exercise program pattern, there will come time in spring to cool down. There has to be a time to gather reports from counties, and for state reports to be made to national. But more importantly, we need to evaluate our year's activities in preparation for the next year. An exercise program is only effective if it is continued.

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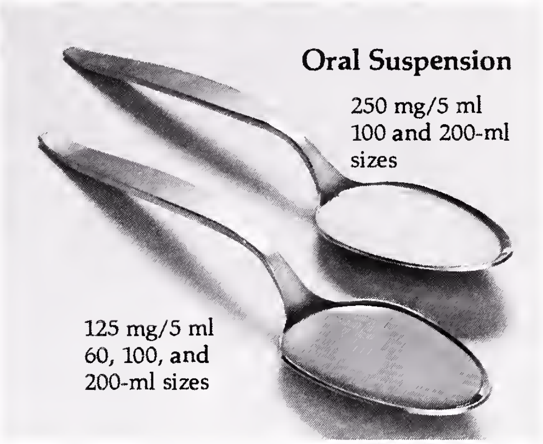
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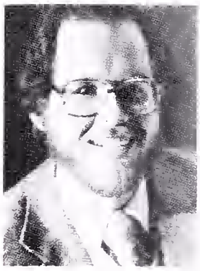
Hillsdale physician aids arrest of alleged prescription defrauder

By Marcia Loader
Hillsdale



Doctor Fowler

A Hillsdale doctor's suspicion and subsequent follow up has culminated in legal charges being brought against a Redford man who allegedly made an illegal attempt to obtain a controlled substance.

Ms. Loader is news editor, *Hillsdale Daily News.*

Larry Fowler, MD, a Hillsdale internist who was assisted by colleague Charles Vear, MD, is credited with recognizing a potential drug racket and rallying the awareness of local doctors and law enforcement officials. The result was an arrest in the Hillsale Community Health Center emergency room July 1.

It all started on June 28. Fowler was winding up a "typically busy" Monday morning when he received a phone call from a person who claimed to be a Doctor Densley of Alpena.

According to Fowler, the caller said one of his female patients was in Hillsdale for a funeral and that she suffered from esophageal cancer which had spread to the bone.

The caller said his patient had run out of medication and that since she would be in the area for three weeks to clear up matters such as the will, property, etc., that she needed three weeks' worth of a drug called dilaudid.

Doctor Fowler was surprised at the request, as, he said, he has never written a prescription for the powerful Class II narcotic in his office — not outside the hospital.

The man who claimed to be "Doctor Densley" told Doctor Fowler his patient needed four-milligram tablets (the strongest dilaudid tablet available). "Then what really tipped me off that this was a scam was when he started telling me how to write the prescription, saying that she needed

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60 tablets to be taken every three to four hours as needed and literally spelling out things that a physician would know," Doctor Fowler said.

The called said the cancer patient was in a wheelchair, ill and therefore unable to come to the office. Instead, a family member would come in and get the prescription.

"Here he wants a prescription for a very strong drug written for a patient that I wouldn't even be seeing. Then he said that this was a very nice family and that they would pay for an office call even though there would be no office call," Doctor Fowler said.

Doctor Fowler said he mentioned to the caller that he had read a Michigan State Medical Society (MSMS) bulletin describing that some people were trying to illegally obtain drugs in a similar manner.

"I told him I needed a family to call locally about this. He asked me 'does the name Johnson or Johnston ring a bell?' — he couldn't remember.' But you see he picked a very ordinary name so I wouldn't be able to track it down," Fowler explained.

Michigan Bell directory assistance lists no Densleys in Alpena, according to Doctor Fowler.

He quickly notified the Michigan State Police — Jonesville post. He also found that Charles Vear, MD, another Hillsdale physician, had been contacted by a man using the same identification and telling the same story with a different patient's name.

Further sleuthing on Doctor Fowler's part turned up a third call. The Hillsdale Community Health Center (HCHC) emergency room was asked to supply a list of names and numbers of physicians who would be contacted in emergency situations.

Fowler then called MSMS and was instructed to contact the FBI. The FBI agent said he doubted Fowler would be contacted again as he had asked too many questions. Preferring to leave the matter in local officials' hands, the agent asked that any further information gleaned be forwarded to the FBI for distribution via bulletin to police, doctors and pharmacists. Doctor Fowler's agency contact was Mark Hopper in the Detroit FBI office.

Vear notified the Hillsdale City Police and the rest of the physicians in town were told to be on the alert.

Two days later, Doctor Fowler was sitting in the HCHC cafeteria with Doctor Frank, assigned that day to emergency room duty. Doctor Frank was called to the telephone. Shortly, he returned and told Doctor Fowler it was "Doctor Densley."

"I told him to go ahead and say he'd fill the prescription, then when someone came to pick it up, we'd catch him. We contacted the city police and then I called the FBI.

"I was talking to the FBI secretary and she told me we shouldn't write the prescription. I asked why and she said the FBI is investigating doctors writing illicit prescriptions. 'Is this a scam or something?' I asked. She wouldn't say one way or another," Fowler said. "I was afraid we'd be arresting an undercover FBI agent.

"Then I talked to an FBI agent who confirmed that the agency was not trying to set the local doctors up because that would be entrapment. But he did say that it might be the Drug Enforcement Agency or the *Detroit News* may be surveying doctors because they are investigating doctors in the state," Fowler said.

The *Detroit News* at the time was probing the use of Medicaid dollars to pay physicians and pharmacies who write and fill large numbers of possibly illicit prescriptions. Their investigations resulted in a multipart series published in the newspaper in June.

The emergency room staff was alerted that someone might come in for the prescription. But the day was uneventful until 6:30 p.m.

"We got a call from the nurses in the emergency room that a man had come in and said that 'Doctor Densley' had called for his aunt. Again, a different name for the patient was used. This way, he apparently planned to get lots of prescriptions under different names," Doctor Fowler said.

The man was described as rather clean cut, wearing a cotton shirt and

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DRUG ARREST/*Continued*

blue jeans. "The nurses said he was really pleasant, but people can be that way when they want something," Doctor Fowler said.

The emergency room staff put him in a room and city police officers went in and arrested him.

"The man calmly said he wanted to talk to his lawyer at that point," Doctor Fowler said.

Police found he was Thomas Joseph Paul of Redford and that he had a warrant standing for another minor offense. He posted $40 bond and was released.

He was not charged with the felony at that time. Doctor Fowler said Prosecutor Michael Smith of Hillsdale County wanted to read the city police report and try to decide if there was enough evidence to try him. A week later, a warrant charging Paul with attempting to obtain a controlled substance by trying to obtain a false prescription was issued by Smith. (Paul was then free on bond.)

Sgt. Michael Stuck of the city police said the decision was made by the prosecutor and added that the physicians and police did an "excellent" job in the case.

Postscript

Thomas Joseph Paul of Redford, the man charged July 1 in Hillsdale with attempting to obtain a controlled substance through a false prescription, was arrested for a drug-related offense 17 days later in Ionia.

Paul's arrest in Ionia was an outcome of Doctor Fowler's intelligent actions in Hillsdale a few weeks earlier to catch the suspect, who allegedly was trying illegally to obtain Class II prescription drugs.

Paul telephoned a pharmacist on July 18 in Ionia. (He was free on bond at the time after his Hillsdale arrest.)

The pharmacist's aunt lives in Hillsdale and had sent the pharmacist a Hillsdale newspaper account of Doctor Fowler's successful cooperation with the police to arrest Paul. The pharmacist was holding a clipping of the newspaper article in her hand as Paul told her he wished to fill a prescription for Dilaudid.

Tipped off by the article, the pharmacist called Doctor Fowler to compare their experiences. This time, Paul allegedly had obtained a physician's drug dispensing license number and had false prescriptions.

Though there were some discrepancies between Doctor Fowler's experience and the Ionia pharmacist's, the pharmacist called state police. They arrested Paul when he came into the pharmacy to fill the prescription, and charged him with attempting to obtain drugs and narcotics under false pretences.

Paul was arraigned on the drug charges July 19 and has been held in custody since while being evaluated for competency to stand trial. He also has been charged with obtaining drugs illegally in Clinton County.

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Numbers of MSMS active and life members grow in last four years

By Deborah Zannoth
East Lansing

MSMS membership tipped the scales at 10,000 on Tuesday, March 9, 1982 with the addition of Keith Y. Miyamota, MD, a urologist from Cheboygan.

At the same time that Doctor Miyamota increased the numbers of MSMS members, he also added his own personal and practice characteristics to the information MSMS stores on its members.

Doctor Miyamota and 9,999 other MSMS members are known to the medical society in various ways, each important to helping MSMS better serve its members.

It is by storing pertinent data on members that MSMS can better design member benefits, mail important CME meeting notices to the proper physicians, represent them persuasively in Lansing and help them obtain fair payment for their services.

In recent months, the MSMS Bureau of Economics has been compiling a basic "membership profile," to better understand the physician population it serves. This article summarizes some of the data gathered.

All membership information is retained in the MSMS master file, which includes much relevant professional data concerning the physician's age, sex, medical specialty, location of medical education, medical speciality affiliation as well as class of membership.

There are 15 membership classes, including the following: active, life, affiliate member, honorary member, medical student, resident (physician in training), first year practice physician, retired and armed service member.

The Bureau of Economics completed the following charts and graphs based on data retained in the master file. The data for each MSMS member is not always available and, therefore, in some categories the information will not always correlate. It is difficult to assess the membership as it changes on a daily basis with the addition as well as the deletion of MSMS members.

The data for this article was (accumulated) on July 9, 1982, and is a reflection of the MSMS membership to date. It will be possible in 1983 to compare data; over the years the Bureau will be able to construct a pattern of the membership.

Data highlights

- **Seven percent of the total membership is female.** This figure represents about half of the women in medical practice in Michigan. (Chart I)
- In a comparison of the membership by age **there is no clustering of physicians in their later years** as might be assumed. MSMS members show a fair distribution by age. (Chart II)
- **Most medical specialities within MSMS membership have grown since 1977.** (Chart III) As noted, not all specialties are included. There have been additions since 1977 such as emergency room medicine, along with changes in names, such as otorhinolaryngology. The chart does not compare MSMS data to total statewide physicians in a specialty due to the fact that the most recent statewide data was collected in 1980.
- **A majority of MSMS members are graduates of Michigan medical schools,** approximately 43 percent (Charts IV, V, VI). Of these, 55 percent graduated from the University of Michigan, 42 percent from Wayne State University and three percent from Michigan State University.
- **FMGs comprise 27 percent of the MSMS membership** and 43 percent of the FMGs are in primary care specialties. Those specialties are family practice, general practice, internal medicine, ob-gyn and pediatrics. There has been a slight decrease (three percent) since 1977. The FMG membership at that time was 30 percent.
- **FMGs comprise half the membership in several county medical societies.** These are Cass County, Clinton County, Huron County, Lapeer County and Monroe County. Lenawee County, Livingston County, Macomb County, St. Clair County and Tuscola County have membership with over 40 percent FMGs.
- **The percentage of US graduates from other states is 30 percent.** (Chart VI) Michigan imports

---

Ms. Zannoth is assistant to the MSMS Bureau of Economics.

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more physicians from Illinois, Ohio, New York and Pennsylvania, than from other states.

- **Membership characteristics have changed over the last four years.** (Chart VII) From 1979 to 1981 there was an increase in active members as well as an increase in life members. However, in 1982 there was a decrease in active members with an increase in life members. Also note the tremendous increase in 1982 of medical student members.

It is important for MSMS to retain data and knowledge regarding MSMS members in order to make sound decisions on important issues. For further information, please feel free to contact the Bureau of Economics.

Chart I

Profile of MSMS Membership by Sex

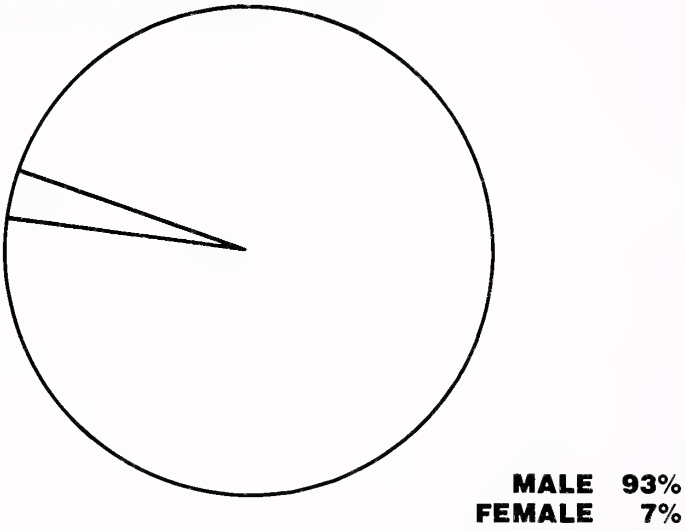

Chart II

MSMS Membership Profile by Age

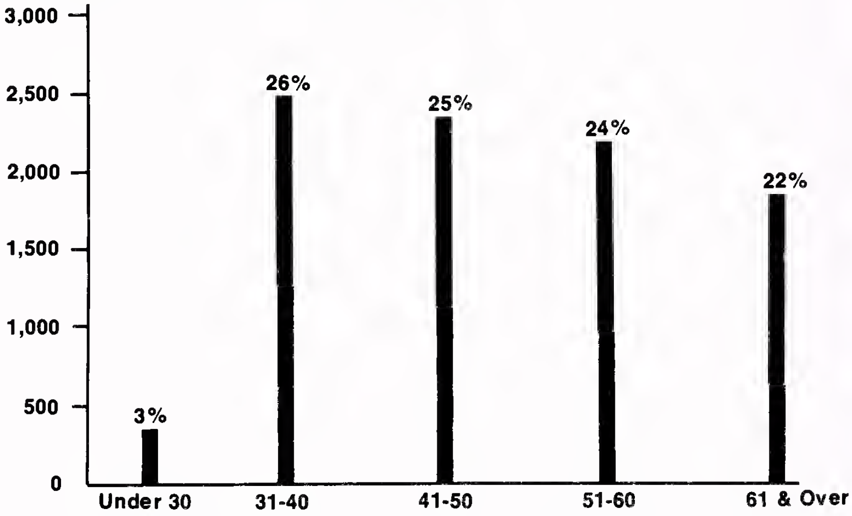

Chart III

Specialty*	MSMS Membership 1977	1982	Percent
Allergy	74	71	− 4%
Anesthesiology	302	394	+30%
Dermatology	130	187	+43%
Family Practice (includes GP and general preventive medicine)	1,589	1,546	− 2%
Gastroenterology	39	51	+30%
General Surgery	392	956	+20%
Internal Medicine	1,240	1,460	+18%
Neurological Surgery	66	82	+24%
Neurology	56	91	+62%
Obstetrics/Gynecology	670	815	+21%
Ophthalmology	292	371	+27%
Orthopedic Surgery	252	349	+38%

Otorhinolaryngology	131	165	+26%
Pathology	267	315	+18%
Pediatrics	404	553	+37%
Physical Medicine	139	52	−62%
Plastic Surgery	55	77	+ 4%
Psychiatry	504	517	+ 3%
Radiology	403	475	+18%
Thoracic Surgery	79	77	− 3%
Urology	165	233	+41%

*Not all specialties included.

Chart IV
Profile of MSMS Membership by Location of Medical Education

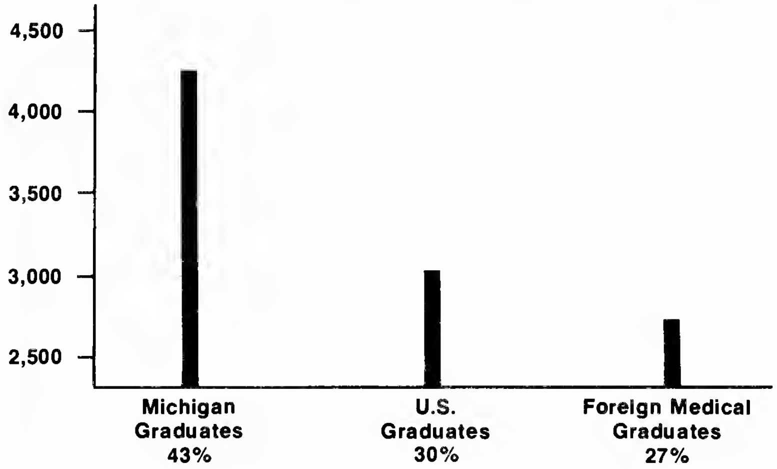

Chart V

Location of Medical Education

County Medical Society	FMGs	Out of State Grads	Michigan Grads	TOTAL
Allegan	1	16	13	30
Alpena-Alcona-Presque Isle	3	13	24	40
Barry	2	8	14	24
Bay-Arenac-Iosco	37	40	48	125
Berrien	42	58	53	153
Branch	6	11	12	29
Calhoun	35	63	66	164
Cass	5	3	2	10
Chippewa-Mackinac	2	15	10	27
Clinton	7	3	4	14
Delta	4	16	15	35
Dickinson-Iron	5	17	17	39
Eaton	2	6	6	14
Genesee	167	135	149	451
Gogebic	—	6	5	11
Grand Traverse-Leelanau-Benzie	8	46	70	124
Gratiot	8	14	11	33
Hillsdale	3	6	9	18
Houghton-Baraga-Keweenaw	13	8	16	37
Huron	14	8	6	28
Ingham	74	173	190	437
Ionia-Montcalm	14	9	13	36
Isabella-Clare	9	15	14	38
Jackson	44	43	64	151
Kalamazoo	62	198	162	422
Kent	66	258	345	669
Lapeer	14	8	6	28
Lenawee	30	17	28	75
Livingston	19	7	13	39
Luce	2	2	4	8
Macomb	146	44	117	307
Manistee	5	6	6	17

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Marquette-Alger	16	49	32	97
Mason	7	5	18	31
Mecosta-Osceola-Lake	2	7	14	23
Menominee	—	7	2	9
North Central	12	14	20	46
Midland	14	37	52	103
Monroe	32	20	12	64
Muskegon	20	85	83	189
Newaygo	—	4	8	12
Northern Michigan	11	49	45	105
Oakland	312	243	564	1,119
Oceana	1	3	4	8
Ontonagon	1	2	4	7
Ottawa	6	32	72	110
Saginaw	85	71	100	256
St. Clair	46	24	40	110
St. Joseph	10	13	10	33
Sanilac	4	1	7	12
Schoolcraft	2	4	3	9
Shiawassee	7	19	16	42
Tuscola	11	2	10	23
Van Buren	10	12	8	30
Washtenaw	86	178	295	559
Wayne	1,054	828	1,235	3,117
Wexford-Missaukee	4	10	16	30
TOTALS	2,602	2,991	4,181	9,777

Chart VI

MSMS Members Graduating From US Medical Schools By State

STATE	NUMBER OF GRADS
Illinois	565
Ohio	319
New York	234
Pennsylvania	230
Wisconsin	161
Indiana	156
Missouri	152
District of Columbia	136
Massachusetts	120
Iowa	119
Tennessee	111
California	96
Maryland	87
Nebraska	76
Minnesota	70
Virginia	43
Texas	35
Kentucky	34
Kansas	32
North Carolina	32
Connecticut	31
Colorado	21
Louisiana	20
Oklahoma	19
Vermont	15
Arkansas	13
Georgia	10
Oregon	10
South Carolina	8
Puerto Rico	7
Utah	5
Washington	5
West Virginia	4
Florida	3
Alabama	2
New Hampshire	2
North Dakota	2
Mississippi	1
South Dakota	1
Not Assigned	5
TOTAL	2,991

Chart VII
MSMS Membership Classification* Comparison Profile

	5-30-79	5-30-80	5-30-81	5-30-82
Active	7,781	7,942	7,984	7,815
(Life)	715	725	777	815
Students	1	0	2	64
Residents	54	49	39	42
1st Yr. Practice	149	196	255	159
TOTAL	8,700	8,912	9,057	8,895

*Not all classifications appear.

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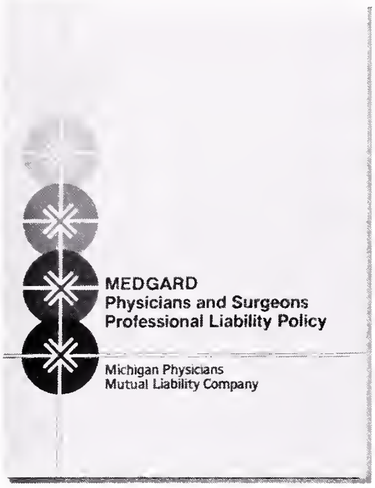

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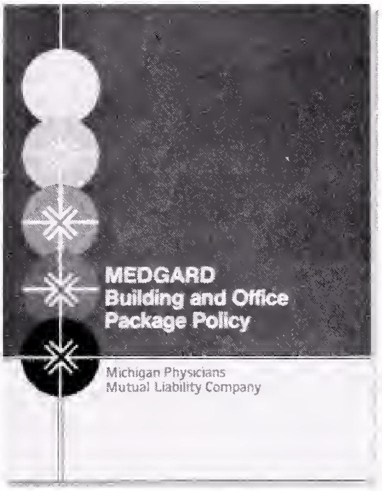

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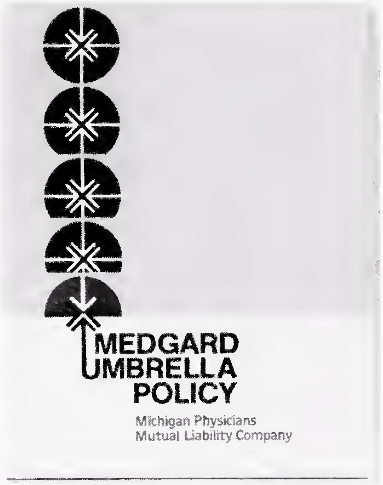

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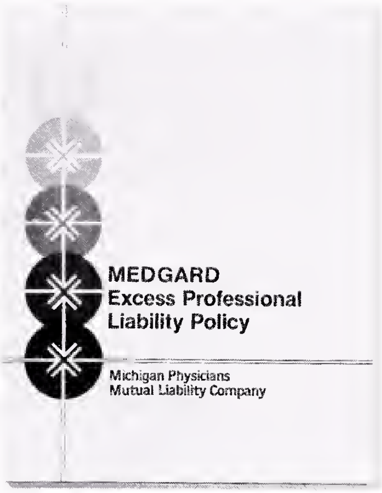

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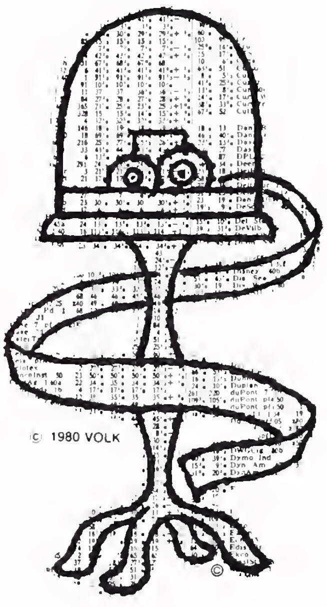
FINANCIAL PLANNING/ INVESTMENT PERSPECTIVES

Alternatives to boost short term after-tax returns

By Daniel L. Ludwin
East Lansing

Editor's note: With this article, *Michigan Medicine* inaugurates a new series of articles to aid physicians in their personal financial planning. Author Daniel L. Ludwin welcomes MSMS members' questions on topics discussed in the articles. Mr. Ludwin will answer specific and unique questions directly, and will prepare further columns in response to questions which could be answered to the benefit of the general membership. Interested physicians may contact Mr. Ludwin by writing MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823.



Mr. Ludwin is senior vice president of Prescott, Ball and Turben, investment bankers and brokers, East Lansing. He is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve funds assets. He has 15 years' experience in the financial field.

Quite understandably, the poor economic climate has contributed to an equally poor 1982 stock market. Furthermore, the inability of Washington to compromise anticipated budget deficits has prolonged record high real interest rates, despite a decline in inflation. As a consequence, many investors have sought refuge in certificates of deposit, treasury securities, and money-market funds. The question arises: Have these investors considered the after-tax investment return?

It is important to remember that the after-tax return from these investments is not the 13 percent currently received, but something less, depending upon the investor's tax bracket. Consider the after-tax return on a 13 percent taxable investment.

Tax Bracket	½ For Taxes	After-Tax Yield
20%	2.6%	10.4%
30%	3.9	9.1
40%	5.2	7.8
50%	6.5	6.5

The 50 percent tax-bracket investor currently earns a 6.5 percent after-tax return on his money-market mutual fund investment which translates into zero real return when adjusted for anticipated 1982 inflation. This return actually becomes a negative number when you take into account the effect of the State of Michigan income tax.

What are the investment alternatives for preservation funds or investment dollars safe from risk?

There are currently three alternatives available to investors. They are: (1) the six-month demand adjustable-rate municipal bond; (2) tax-free short term notes; and (3) the single premium, tax-deferred annuity. A brief description of the investment features and returns of these conservative alternatives follows:

Six-month demand adjustable-rate bonds

This product may sound complicated. However, it is really a simple concept to understand. Typically, adjustable rate bonds are issued by corporations, in the form of industrial development revenue bonds. In addition to the guarantee by the issuing corporation, the bonds also are secured by an irrevocable letter of credit issued by a major bank. As a result, they usually carry a AA or AAA rating.

Similar to other municipals, these bonds are issued in $1,000 increments, normally with a $5,000 minimum investment required to pay interest semi-annually. Maturity ranges from five to 30 years, but this is not a primary consideration.

The two significant features which make this investment different are: (1) Each six months, the coupon (or interest rate) changes, based on an index of 40 AAA-rated, six-month municipal issues. (2) Each six months the investor has the option to put (or tender) the bonds to the seller at par.

Here's how this bond works. The investor buys at the initial rate of $1,000 and receives a fixed tax-free rate of return from the issue date through the first semi-annual interest payment date. Seven business days before the payment date, a new interest rate will be computed (based on the previously mentioned index) for the next six month period. The investor will be advised of the rate he will receive for the next six months. At this time, he may either keep the bond and earn the new tax-free rate or return the bonds at par which is equivalent to the face value. This process will be repeated every six months until the bond matures.

Continued on page 519

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References: **1.** Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **4.** Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*(10):25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **14.** Kales A, Kales JD: *Pharmacol Physicians 4*(9):1-6, Sep 1970. **15.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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More total sleep time on nights 12 to 14 of therapy[4] and continued efficacy for up to 28 nights[5] with

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Rebound insomnia is avoided upon discontinuation [3,4,7] of

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The efficacy of Dalmane has been studied in over 200 clinical trials with more than 10,000 patients.[3-15] During long-term therapy, which is rarely required, periodic blood, kidney and liver function tests should be performed. Contraindicated in patients who are pregnant or hypersensitive to flurazepam.

Please see summary of product information on following page.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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If the occasion warrants, the bond may be sold in the open market at anytime between interest payment dates. While the price will depend upon market conditions, it should be close to $1,000 (par) because of the coming six-month option, to tender the bonds at par.

To put this bond into perspective, it is a high-quality, six-month, tax-free investment — if that's what the investor wants it to be. Should he have no need for his funds, he can opt to receive the new rate for the next six months.

Tax-free notes

Tax-free notes range up to one year in maturity and now yield 8¾ percent on average. While the minimum investment is $5,000, market liquidity for investors wishing to sell notes prior to maturity is poor for investment amounts less than $100,000. After-tax yield, however, is superior for the investor subject to tax brackets exceeding 32 percent (see preceding table). In addition, if Michigan notes are used, the investor would also avoid the State of Michigan income tax.

Single-premium tax-deferred annuities

Deferred annuities offer safety, liquidity, and tax-deferred interest earnings. The investor's original investment is guaranteed by a life insurance company. The deferred annuity is attractive because the Internal Revenue Code provides that during the accumulation period, the income builds free of current taxation. Current yields range from 13 percent to 14¾ percent depending on the product selected. Minimum investments range from $2,500 to $50,000.

Many products carry no front-end sales charges; however, surrender charges can range between two to seven percent depending on the holding periods.

Note: Current legislation has been proposed which could materially affect the short term liquidity of this alternative. It would be prudent to review any changes with your financial advisor.

During periods of economic instability, investors have generally sought safety in short-term investments without consideration of after-tax return. Depending upon investor preference, there are at least three safe alternatives to taxable, short-term investment income.

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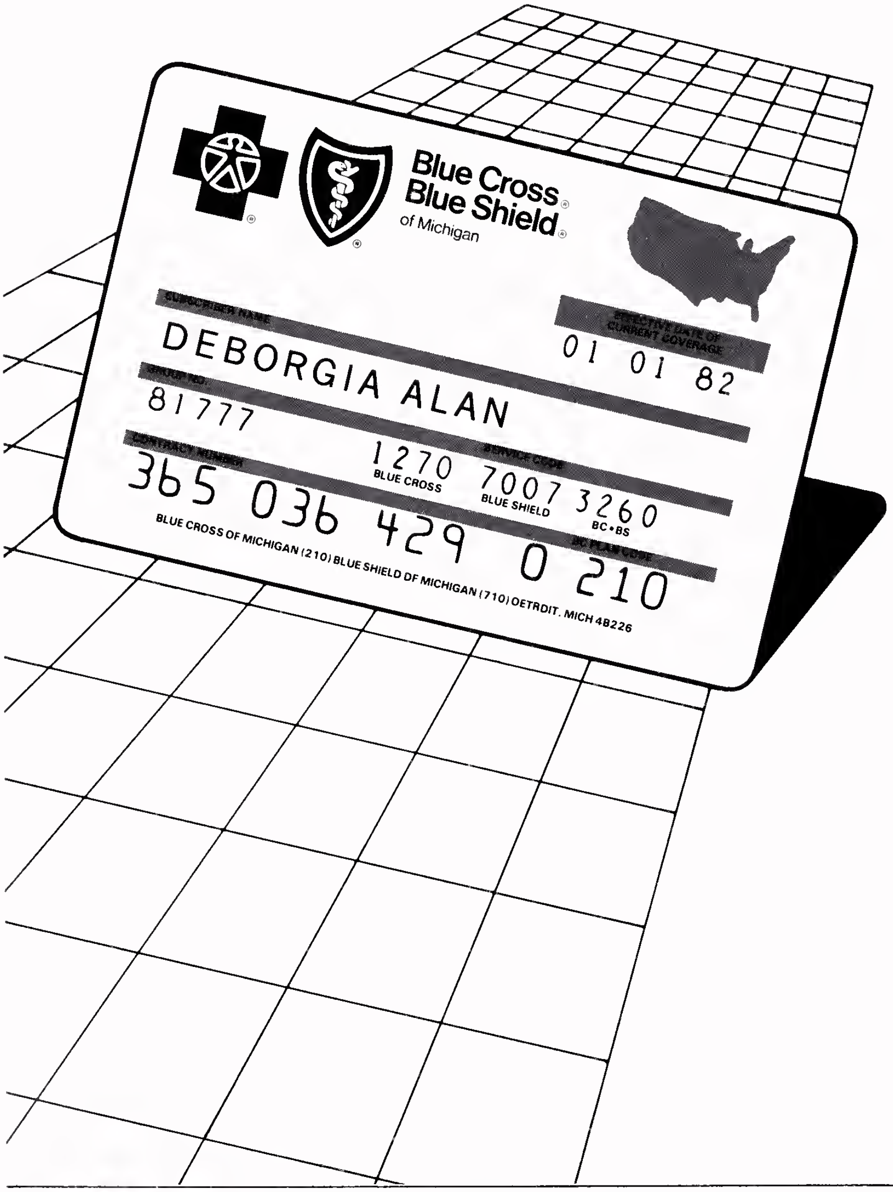
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Now there's a new low-cost health care plan for Michigan State Medical Society members and their employees. It's Dimension III from Blue Cross and Blue Shield of Michigan . . . a health care plan in which the subscriber shares in the cost of the covered services. Dimension III is a lower cost alternative to the other health care plans presently available to doctors and their employees. Here's how the plan works.

Dimension III for doctors:
Deductible — $ 500 one person
$1,000 family

Dimension III for employees:
Deductible — $100 one person
$200 family

Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available:

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For enrollment information, call your local Blue Cross and Blue Shield of Michigan representative.

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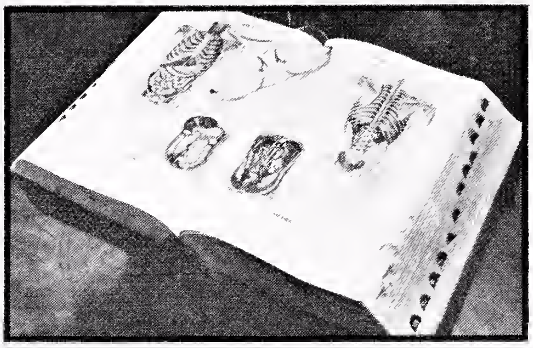

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NEWS

By Sheri W. Greenhoe
East Lansing

Doctor Miyata

Doctor Tanner

The highest honor given by the National Association of Negro Business and Professional Women (NANBPW), the Sojourner Truth Award, was presented to **Natalia M. Tanner, MD,** senior attending pediatrician at Children's Hospital of Michigan, Ann Arbor. The annual award recognizes outstanding leadership and contribution to community service . . . **Roger M. Morrell, PhD, MD,** chief of neurology service at the VA Medical Center, Allen Park, has been elected to a three-year term on the board of trustees of the Michigan Heart Association . . . **Vainutis Vaitkevicius, MD,** chief of oncology at Harper-Grace Hospitals; and **Juan Rojas, MD,** director of the cardiac care unit at Grace, received "teacher of the year" awards at their respective institutions. Doctor Vaitkevicius received the Paul E. Ruble, MD Memorial Award, given each year to the physician who "contributes the most to the education of house staff and students in the department of medicine at Harper Hospital." Doctor Rojas received the Dan W. Myers, MD Memorial Award, given to recognize the recipient's "excellence in teaching skills to medical students." . . . **Joseph Fischoff, MD,** director of psychiatry at Children's Hospital of Michigan, has been named president of the Michigan Psychiatric Society. . . . **Leonard F. Bender, MD,** president and chief executive officer of the Rehabilitation Institute, has been awarded membership in the American College of Physician Executives. . . . Jackson physician **Bruce N. Davenport, MD,** has traded his hectic city practice for medical missionary work in the South African country of Transkei. He and his wife, Mildred, will head the Greenville Hospital complex where they served in both 1967 and 1981. . . . **John D. DeMay, MD,** Jackson, is the third generation member of a family that has provided medical service to that community for 100 years. . . . "Volunteer of the Year" for 1981-82 is **Thomas Miyata, MD,** St. Joseph general surgeon. The honor was presented to Doctor Miyata, president elect of the Michigan Heart Association Delegate Assembly, by the Berrien County Heart Unit. . . . **Ernesto Suarez, MD,** Borgess Medical Center surgeon has been named a trustee to the Nazareth College Board. . . . The late **Paul Van Riper, MD,** of Champion in the Upper Peninsula has been memorialized by his son, Charles Van Riper, PhD, in a book, *My Father, Doctor Van,* recently published by the Marquette County Historical Society. The book is a collection of family memories and anecdotes of Doctor Van Riper's life and medical practice during the early 1900s. . . . **R.K. Hart, MD,** Croswell, was honored recently by the Cecil Service Post #255, American Legion, by the establishment of a scholarship fund in his name. The interest from the fund will be used to assist the children of legion members in getting a college education. . . . **Scott Warner Woods, MD,** Ypsilanti, was one of six persons given honorary degrees at Cleary College's commencement recently. Doctor Woods was honored for his contributions to medicine, education and civic affairs. . . . **William H. Beierwaltes, MD,** chief of the Division of Nuclear Medicine at the U-M Hospitals, has received the Hevesy Nuclear Medicine Pioneer Award from the Society of Nuclear Medicine. Doctor Beierwaltes pioneered the use of radioactive compounds to locate and treat cancer. . . . **John Slater, MD,** Dowagiac, will leave for Abidjan, Ivory Coast, within the year to establish a practice at a 50-bed hospital there, manned by himself, another doctor, and an African staff. Twice a week they will see 200 patients and perform surgery. . . . "Faculty Member of the Year" at McLaren General Hospital, Flint is **Loyde Hudson, MD,** according to the residents there.

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More Tips from the Pros.

Getting out of the rough

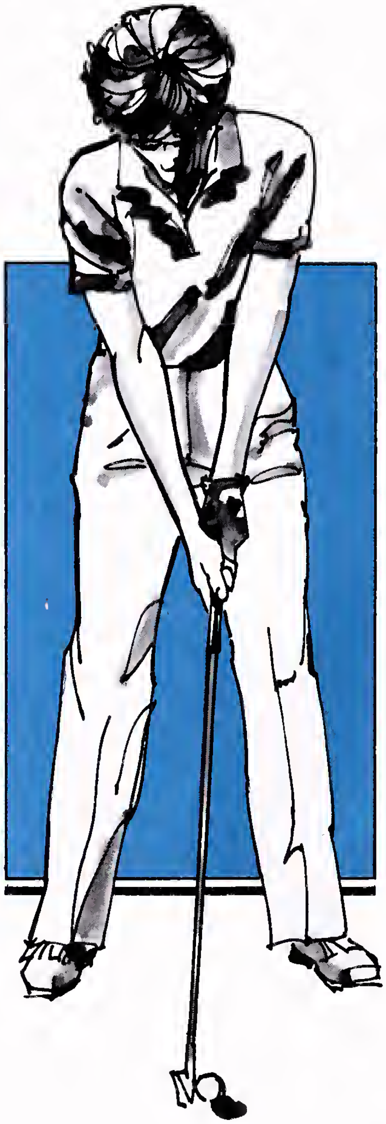
If the ball is really settled in, a long distance shot is impossible. You're better off to sacrifice a little distance by using a wedge or sand iron to get back on the fairway.

You can get considerable distance out of medium rough, if you know how. The grass that's caught between the ball and the clubface will cause the ball to fly with a minimum of underspin. This makes it fly farther. To make it happen, play the ball forward using a 5-iron, open the clubface slightly and swing down at the ball. A normal swing will do it.

Mix up your serves.

A variety of serves can be a psychological advantage over almost any opponent because of the constant confusion and frustration it creates.

Concentrate on a basic serve, preferably a well-paced spin at about three-quarters speed. Try a high-bouncing twist serve once every so often just to catch your opponent off guard. Use your biggest serve with discretion...and then only when you really need it. And remember, just the threat of a big serve in reserve may be all you need to keep your opponent in check.



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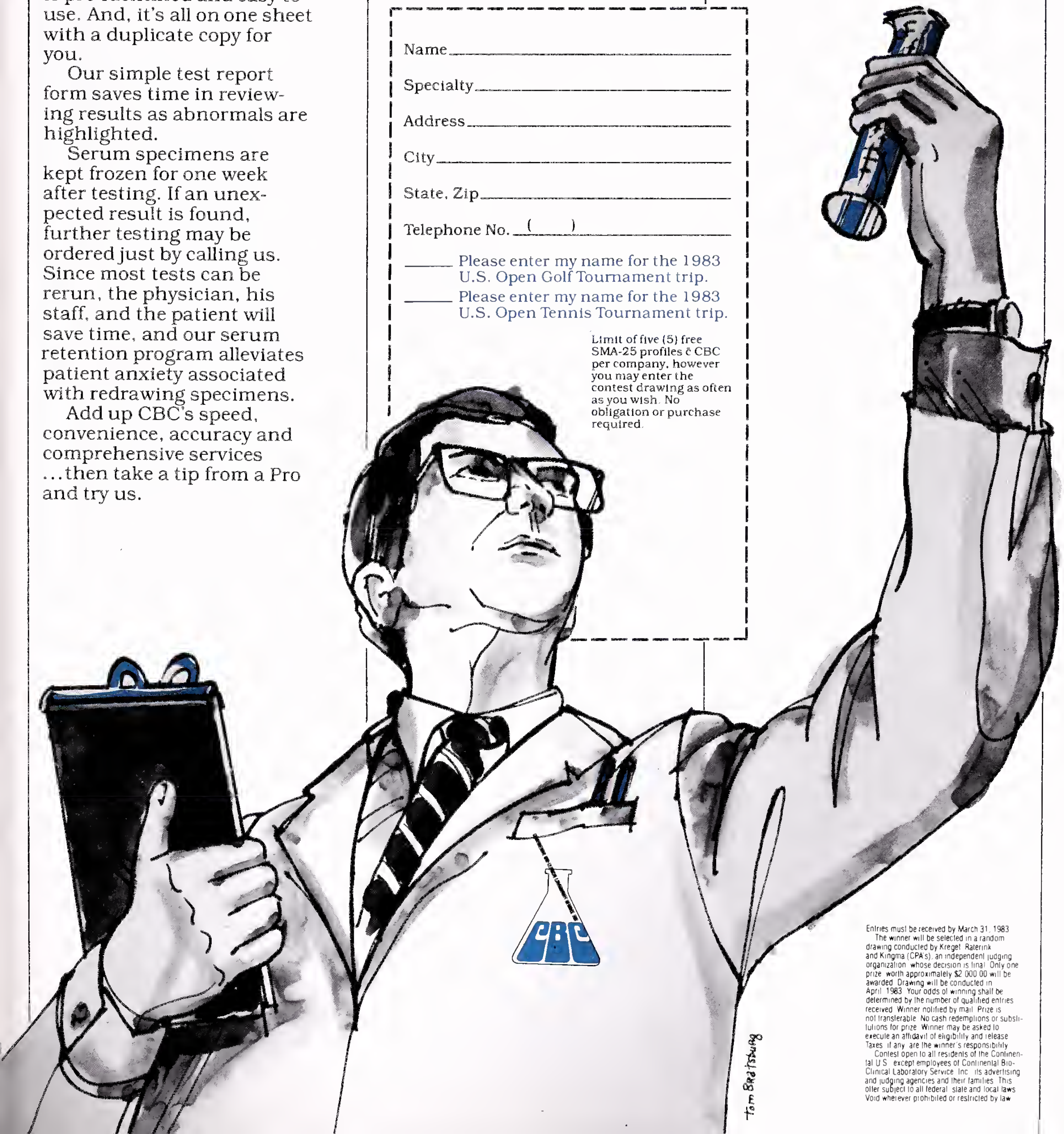

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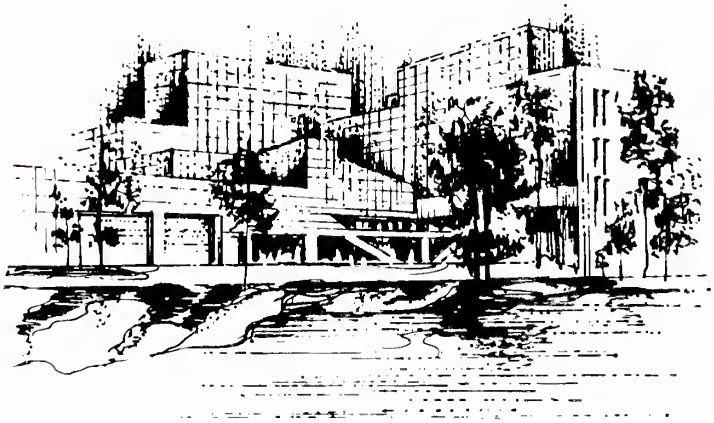

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On the following pages, *Michigan Medicine* presents another in the current series of special articles designed to help Michigan physicians cope with "the challenge of the 80's."

We are talking about the challenging economic and social conditions which are creating more physicians per population than ever before, hence competition for patients; about rising costs of medical care and the growing inability (and reluctance) of people to pay for their care; about the ethical dilemmas posed by medicine's success in prolonging and maintaining life which is limited and tenuous; about growing public demands for education and a major part in decisions affecting health, which cause the physician to become communicator and teacher as well as practitioner.

Previous articles in this series have provided practical advice for improving personal productivity, for taking appropriate credit for good work, staffing the professional office, surveying patients to determine the physician's image with them, and planning for retirement. This month's article describes the important part the physician's office setting plays in patient relationships.

In December, MSMS will publish a manual of detailed information on these subjects and more, complete with bibliographies for further study, to aid MSMS members in today's health care marketplace. The same materials will be available to members on cassette tapes.

The entire effort is a major MSMS member benefit project, and MSMS leaders sincerely hope it will prove useful.

Does your office show you care?

If you are a physician who schedules all office appointments for 2 PM, arrives at your office after hospital rounds at 2:30 PM, and completes examination of patients at 5:45 PM — you'd better have a spacious, attractive, comfortable waiting area.

Even if you don't plan to play the waiting game, and schedule your appointments at reasonable intervals, it's difficult to hold to a precise timetable. Patients inevitably will make use of the reception area.

You need a variety of appealing features to keep your patients, young and old, occupied, intrigued or entertained. Otherwise it's going to be a boring, exasperating wait for them and a rough day for you.

Respondents in a recent national survey reported that on the last visit to the doctor's office some of them waited more than two hours beyond appointment time before seeing the doctor. Seventy-two percent waited six minutes or more; 47 percent waited more than 15 minutes; and 21 percent more than 30 minutes.

This study, made in 1981 by The Gallup Organization, Inc., for the AMA, also indicated that patients' dissatisfaction increased markedly after a 15 minute wait.

Since patients are inclined to be impatient when waiting to see the doctor, and since some time is spent in the waiting area by all patients, the decor and accoutrements of the outer office are especially important.

The appearance and utility of the area may significantly influence patients' receptivity to treatment. The positive or negative vibes patients experience in your waiting room can affect their ability to cooperate fully in the diagnostic procedures and their willingness to follow the doctor's orders.

Whenever the patient is unhappy, the physician's words and instructions are apt to go unheard and unheeded.

"Patients often regard the medical office and its staff as extensions of the doctor's personality, as unspoken expressions of the doctor's attitude toward patients." — from *Impact," American Medical News,* Jan. 30, 1981.

"To such patients, a reception room with uncomfortable furniture, inadequate ventilation, poor lighting, old magazines, and four bare walls is the equivalent of the doctor saying, 'I don't care enough about you to make you comfortable when you come to see me.' "

A doctor out in California may have the answer on how to use the reception area to gain a favorable reaction from patients — he pokes fun at himself, his patients, and life in general.

His office walls are comic relief with such signs as "don't get too well too soon — you're an inspiration to us all" and "liberal credit extended to those over 80 when accompanied by parents."

Richard A. Mahrer, M.D., tells all about his "aggressive fun" in the September (1981) issue of

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This article is a sample selection from the developing MSMS manual, "Meeting the Challenge of the 80's," which will be available to MSMS members in December. Major sections of the manual will deal with practice management, communications, ethics and competition. The manual is the project of the MSMS Committee on Public Service, chaired by Robert D. Burton, MD, Grand Rapids. Excerpts will appear in Michigan Medicine *throughout 1982. They are designed to be removed from the magazine and saved for reference until the entire manual is available.*

Medical Economics under the title *"My office? It's a joke."*

Doctor Mahrer is convinced "the mood an office expresses to a patient plays a vital role in the treatment and even the outcome of illness."

"Medical office decor should produce an environment that relaxes and satisfies the majority of patients . . . What makes our office kind of special are the more than 200 antidepressive signs, quotations, proverbs, posters and old medical ads that cover our walls.

"A few are serious, but most are ridiculous," says Doctor Mahrer.

"Medical offices are especially interesting, because they are generally awful," is the assessment of interior designer Barry Brukoff as reported in *Ideas,* a publication of Herman Miller, Inc., (2/80).

He recommends reception rooms be designed to provide some degree of isolation, with seating arranged into "ones and twos because that's the way people come in." Then they don't have to sit looking at the others, trying to figure out who's contagious.

A definitive description of outer office motif ranging from subtle color and sound to the obvious and practical is presented by Murray Schwartz in *Designing and Building Your Own Office,* published by Medical Economics Co. Book Division, 1981.

The underlying philosophy in decorating and furnishing a physician's office, writes Doctor Schwartz, should be to transmit the message: "Welcome to our office. We're pleased you've chosen us to care for you. We'll do our best to help you."

To produce this atmosphere and convey this message, Doctor Schwartz offers several suggestions, including the following:

- Emphasize soft and rounded shapes in furnishings;
- Select colors for floors, walls and furniture which are restful and pleasing;
- Choose colors in art objects that blend with office color scheme;
- Be sure there is enough space to assure comfort;
- Keep the office air fresh with adequate ventilation;
- Control the sound level with background music;
- Maintain comfortable temperatures;
- Be certain that the patients' lavatory is always clean and supplied with toilet tissue, paper towels, and paper cups.

Doctor Schwartz believes the office reception area should not be decorated and furnished as if it were the physician's home, suggesting that the decor which pleases the family may not appeal to patients.

However, some physicians prefer a home living-room atmosphere. In a spacious area they arrange comfortable furniture to give an appearance of unplanned informality.

Most authorities on office planning agree that there should be:

- Well-lighted reception room with special attention to areas where reading materials are available;
- Separate room, if possible, where babies and young children can be attended by their parent(s) and where games, books and toys are provided for them;
- Current copies of popular periodicals — outdated editions reflect unfavorably on the physician's image as an updated doctor;

Other finishing touches which often are recommended include:

- Photographic art — preferably enlarged prints of quiet, pastoral scenes;
- Diplomas, certificates and special awards — tastefully displayed, attesting to professional credibility;
- Colorful plants (non-poisonous) with special grow lights if necessary;
- Aquarium.

Printed materials, for free distribution, may be displayed on a special rack which will accomodate multiple copies of brochures and leaflets.

These should be selected carefully with emphasis on prevention of health problems. Stick to those which present positive reasons for maintaining good health. Avoid pamphlets which threaten dire consequences. The latter are prone to exaggeration and rejection— they may turn off more people than they turn on.

Brochures on office policies and procedures, including billing practices, are appropriate.

To convey the message that you, as a physician, have a personal interest in individual patients is difficult. Few people come to your office on a social call or seek your help with joyful anticipation.

Many factors, in addition to your personality and professional ability influence acceptance of you and the treatment you prescribe. It is as important for you to have an attractive, well-appointed, functional office as it is to have a courteous, intelligent, sensitive receptionist.

The unobtrusive, often subliminal, communication delivered through your office motif can serve as a statement that you really do care.

As one of the primary communication media at your command, your office can reduce the patient's level of anxiety, and contribute to feelings of well-being and willingness to participate in the diagnosis and treatment process.

Self-insurance saves you money, but it needs the care of a money manager.

Many hospitals have found significant savings in self-insuring their malpractice coverage. In fact, in-hospital coverage of workmen's compensation and other employee benefit programs such as dental, health, disability and group life insurance has dramatically increased the use of self-insurance in medical institutions.

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It is the opinion of the MSMS Judicial Commission

The MSMS Judicial Commission begins, with this issue, to publish its opinions for the benefit of the members. These reports of Judicial Commission opinions will appear periodically in the magazine to help inform members. Physicians might wish to clip these items from the magazine and save them for future reference. Current chairman of the Judicial Commission is Harold A. Machin, MD, Kalamazoo. Commission members are Edwin R. Guise, MD, Detroit; Raymond C. Husband, MD, Detroit; Charles N. Inniss, MD, Detroit; Adam C. McClay, MD, Traverse City; John H. McLaughlin, MD, Birmingham; Richard J. McMurray, MD, Flint; Joseph L. Ponka, MD, Detroit; George D. Stilwill, MD, Lansing, and John C. Rienstra, MD, Grand Rapids.

Thrust of the Judicial Commission

The Judicial Commission meets approximately four times annually. Controversial issues related to medical ethics are reviewed, discussed and resolved. Component medical societies through ethics committees are effective in resolving most problems that arise. The Commission feels that most disputes are best settled at the site of origin. However, when appropriately called upon, the Commission is willing to tender its opinion regarding ethical practice matters of statewide interest. In order to give the reader a better understanding of our activities, the Judicial Commission has decided to publish some earlier decisions. These will be brief.

What is a Medical "Clinic?"

A medical "clinic" should consist of a group of physicians capable of providing a variety of services. They may practice in one or more specialty areas. Their activities go beyond services provided by a single practitioner.

Other individuals, such as opticians, technicians, etc., do not fulfill the criteria for the designation of a "clinic."

A "clinic" therefore includes more than one physician. In this setting they are subject to the same principles of ethics as apply to the membership of the American Medical Association.

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VIEWS

Annual synthetic chemical yield now 200 billion pounds/year

By Bailus Walker Jr., PhD, MPH
Lansing

The issue of toxic substances has the attention of health scientists, medical practitioners, advocates, policy makers, and critics who confer in a never-ceasing stream of publications, conferences, and symposia.

There are three themes they discuss repeatedly in these forums:

1. The extent of human exposure to toxic substance.

2. Risk assessment: the probability of developing a specific disease consequent to exposure to one or more toxic agents in the environment.

3. Regulatory policies and procedures for preventing exposure.

This presentation speaks to the magnitude of human exposure. The other two themes will be addressed in future reports.

There has been substantial growth in overall chemical activity during the last 25 years. Production levels of synthetic organic chemicals have doubled every five to six years, and the total production is now over 200 billion pounds per year.

Exposures to a chemical however, are not directly proportional to its production or use. In the use category two types are recognized: *contained* use and *dispersive* use. *Contained* uses are those in which the chemical is not systematically released into the environment as a direct result of use: lead in cans, plasticizers in vinyl upholstery, asbestos in fireproof clothing, PCBs in transformers. *Dispersive* uses are those in which the chemical is released into the environment as a direct consequence of use (e.g. solvents in paint, lead in gasoline, and pesticides).

In general, those uses designated *contained* will not introduce large quantities of chemicals to the environment during the use stage, but careful attention must be given to disposal.

The use of consumer products, ranging from dishwashing detergents to paint removers, can result in significant exposure to toxic chemicals regardless of precautions advised by the manufacturers. Another source of dermal exposure is residue of washday products in laundered clothes such as fluorescent whitening agents implicated in carcinogenesis. Ingestion may result from contamination of cooking and eating utensils and from failure of the user to wash his or her hands before eating following exposure. Exposure through inhalation is particularly important since the air within a dosed house may contain aerosols or gaseous chemicals introduced by use of fuels, household cleaners, paints and solvents. It may be possible to determine the level of such exposures experimentally with existing analytical techniques. Exposures may be estimated from release rate of chemicals and ventilation rates in homes. However, the wide variation in human behavior, use of household chemicals and house construction complicate such modeling activities.

Although Michigan is surrounded by one of the nation's largest sources of surface waters (rivers and lakes), the state is heavily dependent on groundwater (shallow and deep wells). Forty-nine percent of the residents of the state (almost 4.5 million people) depend on groundwater as a source of water for primary and secondary uses.

Over the past four or five years, toxic substances have been identified in several hundred sites across the state. While many of the organic chemicals found in drinking water wells have been tested in the laboratory for acute and chronic toxicity, there is little evidence to implicate them as the cause of adverse human health effects except in certain occupational settings.

This problem may be further compounded by the fact that groundwaters are frequently taken from seams in solid rock formations under circumstances which make it impossible to know whether they represent infiltration from an adjacent source of contaminiation or have their origin from a watershed many miles away. Only a rather complete knowledge of the geology of the region will provide any clue to the actual history and possible source of chemical pollution.

Perhaps the most serious source of human exposure is in the workplace. In fact, almost all substances recognized as being carcinogenic were first identified as such in occupational settings where workers are exposed to higher concentrations of chemicals than in the non-occupational environment.

While there is considerable focus on industrial chemicals, most chemicals, chemical mixtures, and chemical products are not known to cause serious harm under safe and normal conditions of use and exposure. Modern society has come to depend heavily upon them for health, safety, scientific and technological achievement, environmental quality modification, recreation and many other benefits.

There is, unfortunately, widespread belief that most chemicals cause cancer. This is an entirely misleading idea. First many of the materials cited in the newspaper headlines are chemically related. These chemicals may act in similar ways to produce cancer although it is not yet possible to predict, on the basis of chemical structure alone, which chemicals are carcinogenic. In addition, the tests that exonerate chemicals tend not to reach public notice. Not only does the popular press consider such tests as "nonevents," but the tests have rarely been published even in the scientific literature.

Finally, the assessment of human exposures to environmental toxicants is limited in some instances by inadequate measurement techniques. In such instances research and development of environmental measurement techniques should be expanded.

Doctor Walker is director, Michigan Department of Public Health. This is the first in a series of articles which he will contribute to *Michigan Medicine*.

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ENTERO-TEST® Adult, and Pediatric, a nylon line coiled inside of a gelatin capsule. The Pediatric string is 90cm and the Adult string is 140cm. Both capsules are designed to retrieve duodenal contents without intubation.

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Studies have confirmed the following applications for the Entero-Test:

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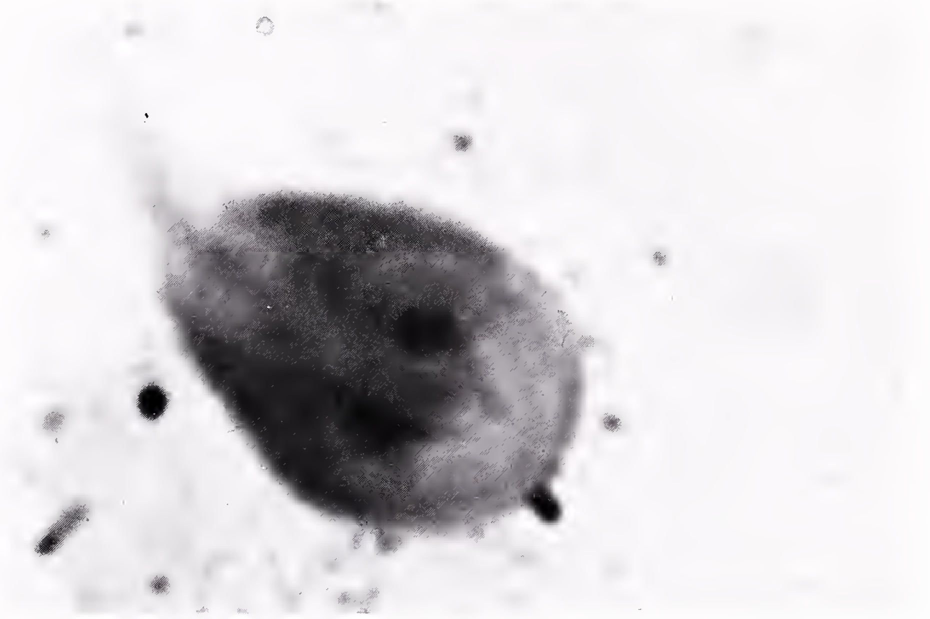
Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include Giardia lamblia (motile trophozoites), Strongyloides stercoralis (larvae and/or eggs in advanced stages of development), Clonorchis sinensis (eggs), Fasciola hepatica (eggs), Trichostrongylus orientalis (eggs), and Isospora (coccidia).

SALMONELLA TYPHI:

Multiple stool exams cultured over several weeks or duodenal intubation are the most commonly used procedures. The Entero-Test is as efficient as intubation but simpler and more comfortable. New studies have further confirmed superior applicability over other procedures.

SMALL INTESTINAL MICROFLORA (Bacterial overgrowth):

Chronic Diarrhea caused by anaerobic and aerobic bacteria in infants and children was easily identified using the Entero-Test. The string test was comparable to or better than duodenal aspirate in all cases.



Giardia lamblia

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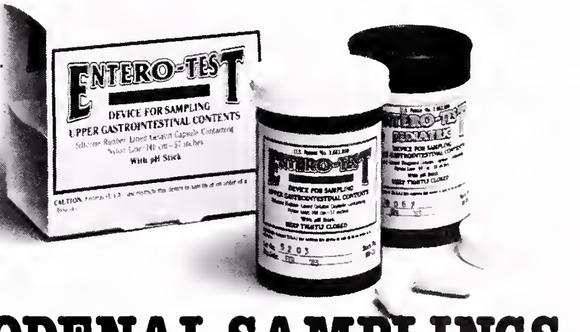

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MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

Oct. 1-14 — MSMS/INTRAV Nile River Adventure, contact Marce Ireland, MSMS headquarters, 517/337-1351.

Oct. 10-12 — MSMS/A National Leadership Conference, Drake Hotel, Chicago, contact Caroline Rich, MSMS headquarters, 517/337-1351.

Oct. 27 — MSMS Component society executives' session, Lansing, contact: Wayne Burmeister, MSMS headquarters.

Oct. 28 — MSMS Leadership/Public Affairs Conference, Long's Convention Center, Lansing, contact: Bill Madigan or Kevin Kelly at MSMS headquarters.

Nov. 6-7 — Medical Assistants Fall Leadership Training Seminar, "Chase the Rainbow," Kalamazoo Center, Hilton Hotel, contact: Margaret Gray, CMA-C, 23548 Lauren Lane, Warren 48089 (313) 777-2827 or (313) 573-4820 (afternoons).

Nov. 8 — MSMS/A State Board Meeting, MSMS headquarters, contact: Caroline Rich, 517/337-1351.

Nov. 9-10-11 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Jan. 29-30, 1983 — Medical Assistants Midwinter Seminar, "Up, Up and Away with AAMA," Eastpointe Chapter, Michigan Inn, Southfield, contact: Margaret Gray, CMA-C, 23548 Lauren Lane, Warren 48089 (313) 777-2827 or (313) 573-4820 (afternoons).

March 6, 1983 — Medical Assistants State Board Meeting, MSMS headquarters, East Lansing, contact Margaret Gray, CMA-C, 23548 Lauren Lane, Warren 48089 (313) 777-2827 or (313) 573-4820 (afternoons).

Other meetings

Sept. 17-19 — "EMS in Our Lives" conference, Michigan Association of Emergency Medical Technicians, Hyatt Regency, Dearborn, contact: MAEMT Convention Registrar, PO Box 118, Union Lake, MI 48085.

Sept. 29-Oct. 1 — Michigan Society for Respiratory Therapy Annual Northern Michigan Michigan Clinical Seminar, Grand Hotel, Mackinac Island, contact: Lee Ras, RRT, c/o Respiratory Therapy, Northern Michigan Hospitals, Petoskey 49770.

Oct. 2 — Michigan Chapter of American Medical Writers Association medical writing workshop, "From the Rat to the Reader," Holiday Inn, Kalamazoo, contact: Jan Carnes, Upjohn Company (616) 323-6153, or Doctor Cornett, Henry Ford Hospital (313) 876-2028.

Nov. 10 — Michigan Society of General Surgeons Annual Membership Meeting, Hyatt Regency Dearborn, contact Caroline Rich, MSMS headquarters, (517) 337-1351.

CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Sept. 25-26, 10th Annual Medical Meeting. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinic Medical Center. **Cost:** $120. **Contact:** Philip E. Hills, MD, Chairman, Burns Clinic Medical Center, Petoskey 49770 (616) 348-4500. **Approved for:** 12 hours of Category I Credit.

Date: Sept. 29, Fall Clinical Day on Infectious Disease. Location: Civic Center, Marshall. **Co-sponsors:** Southwestern Michigan Area Health Education Center and Oaklawn Hospital. **Cost:** $60 in advance for physicians, $45 all others, $70 on registration day for physicians, $55 all others. **Contact:** Judith B. Willis, MA, PA-C, Director, Regional Medical Education & Research, SMAHEC, Stryker Center, 4th Floor, Kalamazoo, MI 49001. **Approved For:** 7 hours of Category I Credit.

Date: Sept. 29, Seminar on Aspiration Needle Biopsy: A Team Approach. Location: Room 2055 Education and Research Center. **Sponsor:** Henry Ford Hospital. **For:** General practitioner, internist, surgeon, radiologist and pathologist. **Cost:** $125. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** Approx. 7 hours of Category I Credit.

Date: Sept. 30-Oct. 2, Perinatology/Neonatology, 1972-1982, Clinical Advances. Location: Towsley Center for Continuing Medical Education, Ann Arbor. **Sponsor:** U-M Office of CME, Dept. of Postgraduate Medicine and Health Professions Education in cooperation with the Dept. of OB/GYN and the Dept. of Pediatrics. **For:** Practicing obstetricians/gynecologists, pediatricians, neonatologists, perinatologists, and related health care professionals. **Cost:** $195. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Box 057, Towsley Center, U-M, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 11 hours of Category I credit.

Date: October 4-5, Advanced Nurse Triage: Planning, Implementation, and Evaluation. Location: Towsley Center for CME, U-M, Ann Arbor. **Sponsor:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, in cooperation with U-M Hospitals and Emergency Services. **For:** All emergency department personnel. **Cost:** $195 for practicing physicians, $135 for physicians-in-training. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14 hours of Category I Credit.

Date: October 6-8, Problems In Internal Medicine: Second Annual Review. Location: Room 2055 Education and Research Center. **Sponsor:** Henry Ford Hospital. **For:** Internists, general and family practitioners. **Cost:** $200. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-1464. **Approved for:** Approx. 18 hours of Category I Credit.

Date: October 11, Selected Short Subjects in Anatomic Pathology. Location: Towsley Center for CME, U-M Medical School, Ann Arbor. **Sponsor:** U-M Medical School, Office of CME, Dept. of Postgraduate Medicine and Health Professions Education and the Department of Pathology. **For:** Practicing pathologists and scientifically-oriented clinicians. **Cost:** $95. **Contact:** Office of CME, Towsley Center for CME, U-M Medical School, Box 057, Ann Arbor 48109 (313) 763-1400. **Approved for:** 7 hours of Category I Credit.

Date: October 13, The Role Of The Non-invasive Vascular Laboratory." Location: Kalamazoo Hilton Inn, 100 W. Michigan Avenue, Kalamazoo. **Co-sponsors:** Southwestern Michigan Area Health Education Center and Regional Vascular Surgery Center. **For:** All interested physicians. **Cost:** $70 in advance for physicians, $55 all others, $80 on registration day for physicians, $65 all others. **Contact:** Charles L. Zeller, Jr., MD, Director of Continuing Medical Education, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 14-17, Annual Regional Meeting of the Michigan Chapter, American College of Physicians. Location: Traverse City Hilton. **Sponsor:** American College of Physicians, in association with the Michigan Society of Internal Medicine. **Contact:** Arnold R. Axel-

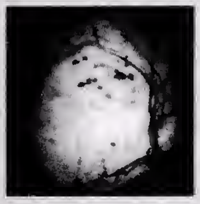
Continued on page 536

WE HAVE A SOLUTION FOR A DIFFICULT UROLOGICAL PROBLEM

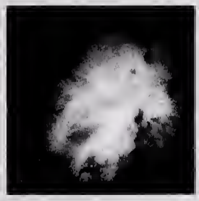
The Problem

SYMPTOMS:

EARLY INTERSTITIAL CYSTITIS



CLASSICAL INTERSTITIAL CYSTITIS



- ☐ irritative voiding symptoms
- ☐ suprapubic pain
- ☐ functional bladder capacity reduced
- ☐ anatomical bladder capacity:
  - EARLY — normal
  - CLASSICAL — reduced
- ☐ vesical mucosa:
  - EARLY — normal appearing
  - CLASSICAL — ulcerated, scarred
- ☐ submucosal vesical hemorrhages observed following second overdistension

DIAGNOSIS: INTERSTITIAL CYSTITIS

The Solution

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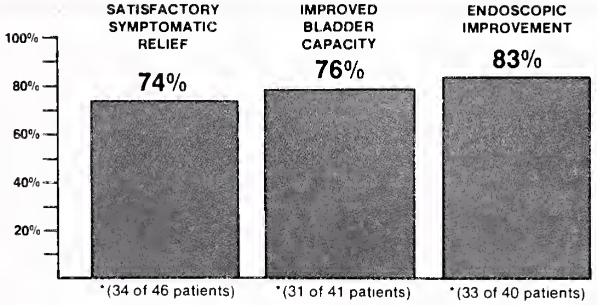
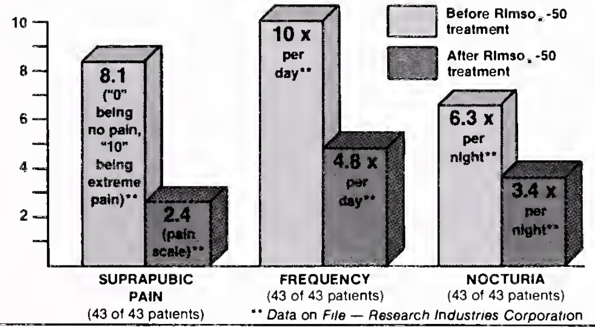


* STEWART, B.H., et al., *J. Urol.*, 36:116, 1976



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Rimso®-50
(dimethyl sulfoxide)
50% w/w aqueous solution

INDICATIONS AND USAGE: Rimso®-50 (dimethyl sulfoxide) is indicated for the symptomatic relief of patients with interstitial cystitis. Rimso®-50 has not been approved as being safe and effective for any other indication. There is no clinical evidence of effectiveness of dimethyl sulfoxide in the treatment of bacterial infections of the urinary tract.

CONTRAINDICATIONS: None known.

WARNINGS: Dimethyl sulfoxide can initiate the liberation of histamine and there has been occasional hypersensitivity reaction with topical administration of dimethyl sulfoxide. This hypersensitivity has been reported in one patient receiving intravesical Rimso®-50. The physician should be cognizant of this possibility in prescribing Rimso®-50. If anaphylactoid symptoms develop, appropriate therapy should be instituted.

PRECAUTIONS: Changes in the refractive index and lens opacities have been seen in monkeys, dogs and rabbits given high doses of dimethyl sulfoxide chronically. Since lens changes were noted in animals, full eye evaluations, including slit lamp examinations, are recommended prior to and periodically during treatment. Approximately every six months patients receiving dimethyl sulfoxide should have a biochemical screening, particularly liver and renal function tests, and complete blood count.

Intravesical instillation of Rimso®-50 may be harmful to patients with urinary tract malignancy because of dimethyl sulfoxide-induced vasodilation. Some data indicate that dimethyl sulfoxide potentiates other concomitantly administered medications.

Pregnancy Category C. Dimethyl sulfoxide caused teratogenic responses in hamsters, rats, and mice when administered intraperitoneally at high doses (2.5-12 gm/kg). Oral or topical doses of dimethyl sulfoxide did not cause problems of reproduction in rats, mice and hamsters. Topical doses (5 gm/kg first two days, then 2.5 gm/kg - last eight days) produced terata in rabbits, but in another study, topical doses of 1.1 gm/kg days 3 through 16 of gestation failed to produce any abnormalities. There are no adequate and well controlled studies in pregnant women. Dimethyl sulfoxide should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when dimethyl sulfoxide is administered to a nursing woman.

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: A garlic-like taste may be noted by the patient within a few minutes after instillation of Rimso®-50 (dimethyl sulfoxide). This taste may last several hours and because of the presence of metabolites, an odor on the breath and skin may remain for 72 hours.

Transient chemical cystitis has been noted following instillation of dimethyl sulfoxide. The patient may experience moderately severe discomfort on administration. Usually this becomes less prominent with repeated administration.

DOSAGE AND ADMINISTRATION: Instillation of 50 ml of Rimso®-50 (dimethyl sulfoxide) directly into the bladder may be accomplished by catheter or asepto syringe and allowed to remain for 15 minutes. Application of an analgesic lubricant gel such as lidocaine jelly to the urethra is suggested prior to insertion of the catheter to avoid spasm. The medication is expelled by spontaneous voiding. It is recommended that the treatment be repeated every two weeks until maximum symptomatic relief is obtained. Thereafter, time intervals between therapy may be increased appropriately.

Administration of oral analgesic medication or suppositories containing belladonna and opium prior to the instillation of Rimso®-50 can reduce bladder spasm.

In patients with severe interstitial cystitis with very sensitive bladders, the initial treatment, and possibly the second and third (depending on patient response) should be done under anesthesia. (Saddle block has been suggested).

HOW SUPPLIED:

Bottles contain 50 ml of sterile and pyrogen-free Rimso®-50 (50% w/w dimethyl sulfoxide aqueous solution).

Dimethyl sulfoxide is clear and colorless.

Protect from strong light.

Store at room temperature (15° to 30° C).

Do not autoclave.

NDC #0433-0433-05.

*Stewart, B.H., et al., *J. Urol.*, 36:116, 1976

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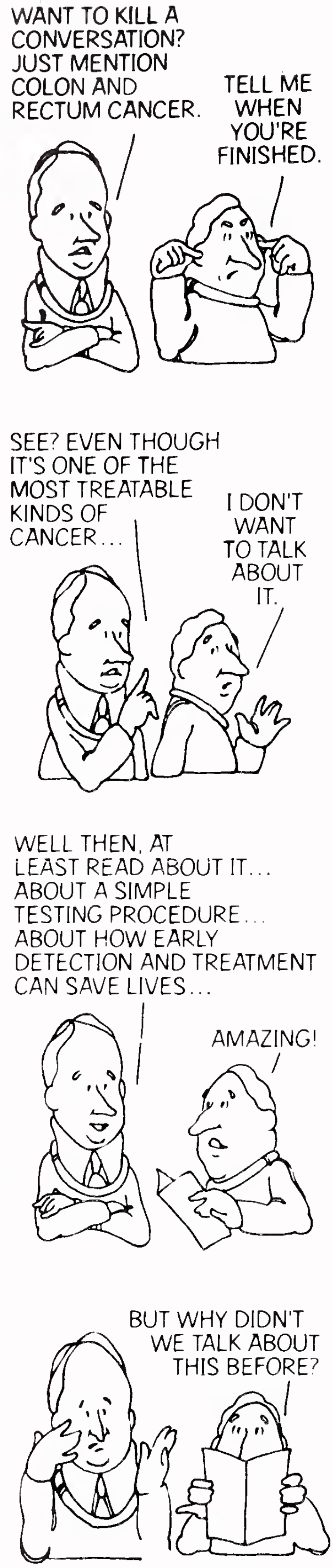
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CATEGORY I/Continued

rod, MD, Sinai Hospital of Detroit, (313) 493-5780. **Approved for:** 25 hours of Category I Credit.

Date: October 15-16, Cardiac Rehabilitation. Location: Hyatt Regency Dearborn. **Sponsor:** International Medical Education Corporation. **Cost:** $245. **Contact:** Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, Division of Postgraduate Education, 64 Inverness Drive East, Englewood, CO 80112 800-525-8651 or 303-740-8445, ext. 123. **Approved for:** 13 hours of Category I Credit.

Date: October 18, Collaborative Practice: Beyond Rhetoric to Reality. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education. **Cost:** $95. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center for CME, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 21-23, 1982 Alumni Reunion Scientific Seminar. Location: Room 2055 Education and Research Center. **Sponsor:** Henry Ford Hospital. **For:** HFH Alumni. **Cost:** $100. **Contact:** Office of Medical Education, Henry Ford Hospital, 2799 W. Grand Blvd., Detroit 48202 (313) 876-1464. **Approved for:** Category I Credit will be granted for attendance at the Scientific Meeting(s) on an hour-for-hour basis.

Date: Oct. 25-29, Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: October 29-30, Injectable Collagen: Investigation, Application, and Techniques. Location: Towsley Center for CME, U-M, Ann Arbor. **Sponsor:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, U-M Medical Center and The Department of Dermatology. **For:** Dermatologists, dermatological surgeons, head and neck surgeons, and others interested in reconstructive surgery of the skin. **Cost:** $155. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: Nov. 1-5, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Kellogg Center, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Nov. 3, 22nd Annual Thyroid Workshop. Location: Gordon H. Scott Hall of Basic Medical Sciences, WSU School of Medicine, Detroit. **Sponsor:** WSU School of Medicine, Dept. of Internal Medicine, Division of Endocrinology. **For:** Endocrinologists, family physicians, general surgeons and internists. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 8-10. Manual Medicine to the Extremities. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Nov. 9-11. MSMS Annual Scientific Meeting. Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** Sherry Fent, MSMS headquarters (517) 337-1351. **Approved for:** Up to 18 hours of Category I Credit.

Date: Nov. 18-19-20, Acute Injuries of the Hand: Primary and Definitive Care. Location: Westin Hotel, Detroit. **Sponsor:** WSU School of Medicine Department of Surgery. **Contact:** WSU School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 19 hours of Category I Credit.

Date: Nov. 20, Surrogate Mother Symposium. Location: McGregor Memorial Conference Center, Wayne State University, Detroit. **Sponsor:** WSU Schools of Medicine and Law. **For:** OB/GYNs and others interested in fertility issues. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 26-30, Ophthalmology: Basic and Clinical Review. Location: Hyatt Regency Dearborn. **Sponsor:** Kresge Eye Institute, WSU School of Medicine. **For:** Practicing and resident ophthalmologists. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 44 hours of Category I Credit.

Date: Dec. 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Dec. 27-31, Clinical Medicine Update II: An Educational Retreat. Location: San Diego. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education. **For:** Clinicians in internal medicine, family practice, general practice, general surgery, pediatrics, and obstetrics and gynecology. **Cost:** $325. **Contact:** Office of CME, Towsley Center for CME, U-M Medical School, Box 057, Ann Arbor 48109 (313) 763-1400. **Approved for:** 18 hours of Category I Credit.

Date: Feb. 13-19, 1983, Myocardial Infarction and Angina Pectoris. Location: Davos, Switzerland. **Sponsor:** Division of Cardiology of the Hannover Medical School, Hannover, West Germany, and the University of Michigan. **For:** All physicians and surgeons with an interest in ischemic heart disease. **Cost:** $300. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center for CME, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 28 hours of Category I Credit.

Date: Feb. 23-March 1, 1983, Adolescent/Young Adult Medicine. Location: Wailea Beach Hotel, Maui, Hawaii. **Sponsor:** Hurley Medical Center, Department of CME. **Contact:** Hurley Medical Center, Dept. of CME, One Hurley Plaza, Flint 48502, (313) 766-0142. **Approved for:** 20 hours of Category I Credit.

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DEATHS

Doctor Adler

Sidney Adler, MD
Southfield

Sidney Adler, MD, Southfield, died July 20 at the age of 73. MSMS president in 1971, Doctor Adler earned his medical degree from Johns Hopkins in 1933. He specialized in internal medicine. Considered an authority and pioneer on uses of insulin, Doctor Adler authored many books on the subject. He was a former president of Blue Cross Blue Shield of Michigan, and had been an assistant professor of clinical medicine at Wayne State University. Doctor Adler was a former treasurer for the Wayne County Medical Society, a former MSMS delegate, and a life member of the American College of Physicians. He was a staff member at Harper Hospital, and had been affiliated with Sinai, Crittendon General and Receiving hospitals during the course of his career. A Detroit native, Doctor Adler served as a Navy captain during World War II.

James W. Christophersen, MD
Muskegon

James W. Christophersen, MD, Muskegon general practitioner, died June 28. He was 67. Doctor Christophersen graduated from the University of Michigan Medical School in 1942, and served with the U-M 298th Hospital Unit during World War II. He had been affiliated with both Mercy and Hackley hospitals in Muskegon, and was active in Evangelical Covenant Church. He was a choir member, Sunday school teacher and member of the Christian Education Board. He had been a member of the AMA, the American Academy of Physicians, and the Muskegon Christian Medical Society.

James W. Finn, MD
Mount Clemens

James W. Finn, MD, Mount Clemens, died July 11 at the age of 58. He was an obstetrician/gynecologist in Macomb County for 18 years. Doctor Finn earned his MD at the University of Ottawa, Canada, in 1954, and had been on staff at St. Joseph Hospital East. Past medical director at the Chrysler Stamping Plant in Detroit, Doctor Finn was a member of the American Association for the Advancement of Science, and the Michigan Occupational Medical Society.

Stephen M. Gillespie, MD
Allen Park

Stephen M. Gillespie, MD, Allen Park general practitioner, died July 4. He was 69. Doctor Gillespie earned his medical degree in 1938 at Wayne State University. He was on staff at Oakwood Hospital in Dearborn, and was an emeritus staff member at Mt. Carmel Mercy Hospital. A World War II veteran, Doctor Gillespie was a former MSMS delegate.

Maurice D. Gollman, MD
Southfield

Maurice D. Gollman, MD, Southfield, died July 10 at the age of 77. Doctor Gollman was a retired internist, surgeon and hematologist, and had practiced hematology in Detroit for more than 50 years. He was a former chief of hematology at Grace Hospital, where he taught a residency program. He served as a captain in the US Army Medical Corps in WWII.

Roger J. Hanna, MD
Mason

Roger J. Hanna, MD, Mason, died June 21 at the age of 81. Doctor Hanna was a former superintendent of the old Jackson County Tuberculosis Sanitarium from 1930 until 1953. He earned his MD from Indiana University in 1926, and was a specialist in TB and respiratory diseases. Doctor Hanna had been

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Lenawee County Health Department director, and a medical staff member at Southern Michigan Prison during his career. He retired in 1967 as director, OASI Disability Determination Division, State of Michigan. A former president of the Jackson County Medical Society, and member of the American College of Chest Physicians, Doctor Hanna saw military duty during WWII.

Victor E. Linden, MD
Jackson

Victor E. Linden, MD, Jackson, died June 19 at the age of 74. Doctor Linden, a general practitioner, maintained a practice in Jackson for more than 47 years. He graduated from Ferris State College as a pharmacist, then earned his MD at the U-M in 1935. He was an Army flight surgeon from 1942 until 1945. Doctor Linden was a past president of the Michigan Academy of General Practitioners, now MAFP. In recent years he donated his services as team physician to Jackson Community College athletics.

Harold C. Mack, MD
Tucson, Arizona

Harold C. Mack, MD, formerly of Detroit, died July 11 at the age of 81. Doctor Mack earned his MD in 1925 from the University of Michigan, and maintained a private OB/GYN practice from 1929 until 1970. He was the retired chairman of the Department of Obstetrics and Gynecology at Wayne State University, and was a former chief of OB/GYN at Harper Hospital. Doctor Mack was past president of the Michigan Society of Obstetricians and Gynecologists, the Central Association of Obstetricians and Gynecologists and the Detroit Academy of Medicine. He was past vice president of the American Association of Obstetrics and Gynecology, and a member of the American Gynecological Society. Doctor Mack had been a lieutenant colonel in the Army Medical Corps during WWII.

H. Marvin Pollard, MD
Ann Arbor

H. Marvin Pollard, MD, Ann Arbor, died July 15 at the age of 75. He was an internationally-known authority on gastrointestinal diseases and cancer, and former president of the American Cancer Society. Doctor Pollard, a 1931 University of Michigan Medical School graduate, was a U-M professor emeritus of internal medicine. He had headed a U-M research team that in 1956 invented the first fiberoptic gastroscope, the prototype of the modern diagnostic instrument. Doc-

Continued on page 540

ADVANCES IN ADOLESCENT/YOUNG ADULT MEDICINE

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tor Pollard was past president of the World Organization of Gastroenterology, and had headed the U-M section of gastroenterology for 32 years. He wrote more than 140 articles on cancer of the intestinal tract. In recent years, Doctor Pollard had spend much time raising funds for the H. Marvin Pollard Institute for Medical Research.

Andrew M. Roche, MD
Calumet

Andrew M. Roche, MD, Calumet, died July 6 at the age of 67. Doctor Roche graduated from Georgetown University Medical School in 1939. A general practitioner, he was affiliated with Harper Hospital, and was former chief of staff at Calumet Hospital. Doctor Roche was past president of the Upper Peninsula Medical Society, and had served with the Harper Hospital Field Unit during WWII.

Norman R. Wilson, MD
Fraser

Norman R. Wilson, MD, Fraser, died June 29 at the age of 63. He was a general practitioner. Doctor Wilson graduated from the Wayne State University School of Medicine in 1944, and had been affiliated with St. Joseph hospitals since 1950. A staff physician at Detroit Industrial Clinic since 1974, Doctor Wilson served as a flight surgeon in the US Army Air Force from 1944 until 1947.

Lavern V. Wolfgram, MD
Traverse City

Lavern V. Wolfgram, MD, Traverse City, died in a one-car accident May 31. He was 45. An avid runner, Doctor Wolfgram competed in two Boston Marathons, as well as several local races. He earned his MD from the University of Michigan in 1962, then joined the staff at Munson Medical Center, Traverse City. He became that hospital's chief of family practice, as well as a member of its executive board. Doctor Wolfgram was active in halfway house and substance abuse programs, and was a member of Alpha Omega Alpha Medical Honor Society.

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1982

David Siegel Passes Away

David Siegel, MD, Lansing, 1980-82 Speaker of the MSMS House of Delegates and MSMS Medicaid Liaison Committee chairman, died July 23. He was 57. Doctor Siegel, a noted urologist, had been vice president for medical affairs at E.W. Sparrow Hospital, and was one of the first surgeons to perform kidney transplants in the Lansing area. He had practiced in Lansing since 1954, had served as Sparrow Hospital chief of staff for two terms, and had been chief of the Departments of Urology at Sparrow, Ingham Medical and St. Lawrence hospitals. Doctor Siegel had been very active in organized medicine, and was known to be a stern critic of government programs that discriminated against physicians. He had been a member of the MSMS House of Delegates, the group that last May named him "President for a Day," since 1972, and a member of the AMA House of Delegates since 1976.

At the 1982 MSMS House of Delegates meeting, the delegates elected Doctor Siegel MSMS President for a day, an honor bestowed only three times previously in MSMS history. Above, Doctor Siegel, right, accepts a plaque commemorating the honor from MSMS Speaker Gerald Mandell, MD.

A 1948 graduate of New York Medical College, Doctor Siegel was a Diplomate of the American Board of Urology, a member of the American Urological Association and the North Central Section of the American Urological Association. He was past president of the Michigan Branch of the American Urological Association, the American Association of Clinical Urologists, the Michigan Transplantation Society and Congregation Shaarey Zedek. Doctor Siegel was a captain in the US Medical Corps in Korea, and earned a bronze star for his service.

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Robert E. Paxton, MD, left, MSMS Councilor and alternate delegate to the American Medical Association, met recently with Senator Carl Levin, center, in Washington, DC, to present MSMS arguments for removing learned professions from Federal Trade Commission jurisdiction. Senator Levin granted a lengthy audience to hear the MSMS viewpoints, and expressed sincere understanding of the problem. Doctor Paxton, with Bruce Ambrose, right, MSMS manager of government relations, also called upon five members of the House of Representatives to make the MSMS pitch.

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ORTHOPAEDIC SURGEON, GENERAL SURGEON, AND NEUROLOGIST — Board Certified or eligible, to join young, progressive, 10 doctor multi-specialty primary care group. Competitive salary and excellent fringe benefits. Medical Center community of 40,000 located in S.W. Missouri on the fringe of the Ozarks. Contact Donald Peterson, MD, or Dick Lihigh, Administrator, Patterson-Smith Clinic, 3302 McIntosh Circle, Joplin, MO 64801 (417) 624-1520.

SOLO OB/GYN SEEKS PARTNER in lakeside community. Applicants must have board eligibility. Reply to: Box 32, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

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PRIMARY CARE PHYSICIANS needed for multi-specialty clinic with family practice base. Need primary care general practice internists and general surgeons. Reply with C.V. to Administrator, Redford Medical Center, 25210 Grand River, Detroit, MI 48240.

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Upjohn	517
US Air Force	510
US Army	506

PRESIDENT'S PAGE

Physicians have some control over only 25 percent of health costs

By James H. Tisdel
MSMS President

Editor's note: This column is excerpted from an address Doctor Tisdel made recently to members of the Huron County Medical Society. He is making similar statements at other county medical society meetings around the state, as he works to be known as "one of the traveling MSMS presidents."

The era of competition in medicine is surely upon us. We are keenly aware of high costs and public complaints about hospitalization, insurance premiums, and medical fees. We are likewise aware of the growing numbers of physicians who are for the first time in their professional lives being forced to compete for patients. We all know only too well the impact of third party payors on our practice lives as well as on our incomes. And living in Michigan provides a scenario for multiple problems with Medicaid reimbursements in a totally depressed economy.

Against this backdrop looms the additional spector of expanding hospital satellite clinics, HMO's, PPO's, DRG's, and hospital rate-setting talk. The name of the game is clear. *Cost Containment.* We must seek ways to cut overhead in our offices and in our patient services without affecting the quality of the fine care we deliver. We must be sympathetic to our patients in the face of expensive medical needs. The question is how can we survive and deliver care without compromising our standards? More care is not better care. We are morally and ethically bound to resist over-utilization to maintain income. We must exercise careful judgement when ordering hospitalization, laboratory tests, x-ray exams, etc. We must help our patients avoid unnecessary costs and, we must do what we can to increase our office and personal efficiency to maintain profit margins.

We can learn cost saving methods from each other — to benefit ourselves and those we serve. But what do we tell our patients, friends, community groups, service organizations, churches, and social clubs? What do we tell them about the root causes of medical costs and the pressures we face to hold them down?

This is where I would like your attention; for I am sure we have some answers that each and every doctor ought to make known to all who would hold us — our profession — solely responsible for escalating costs of medical care.

We know that 50 percent of the cost increases we've seen over the past 10 to 12 years are directly related to inflation, and inflation is clearly attributed to government policies of spending far in excess of income.

This inflation affects everyone and especially health care, which is a highly labor intensive and energy intensive industry. So let your patients know 50 percent of escalating costs are directly related to inflation.

We know that government regulations account for 25 percent of our nation's hospital costs, as has been repeatedly demonstrated. The New York hospital authority in a study done four years ago showed that it cost an average of $40 per bed per day in that state just to meet the costs of fulfilling various governmental regulations. Who can guess what it costs now, four years after that study? I do not suggest any regulations, but I suggest the elimination of many.

Then what about the 25 percent over which we can exert some control? We need to trim costs; be prudent over tests we order. I know this is difficult in the fact of the threat of professional liability suits in today's litiginous society, but strive to do it we must.

Much of this 25 percent can be attributed justifiably to (1) our increasing population of roughly 2,000,000 more Americans each year. (2) An ever increasing elderly population, now 10 percent of the total number of citizens. This 10 percent now consumes 30 percent of the health care dollars.

In a very real sense we are victims of our own successes. As we discover cures and treatments for diseases that once claimed large numbers of people, we keep them alive to develop cancers and circulatory problems which costs thousands upon thousands of today's inflated dollars to treat.

And let's not forget today's technology which enables us to prolong life at the family's request or even by legal demand.

The half life of medical knowledge today is roughly seven years, which means we are replacing all our technology every seven years while relearning new medicine at the same time. This is an expense over which we have no control, short of saying we will not choose to advance our knowledge.

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Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

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a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
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in shigellosis...
faster relief of diarrhea than with ampicillin[2]

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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note.* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

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Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

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* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

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MICHIGAN MEDICINE

October 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 81, No. 46

COLLEGE OF PHYSICIANS PHILADELPHIA OCT 26 1982

The candidates and health care

Deal yourself in!

1982 MSMS Annual Scientific Meeting

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MICHIGAN MEDICINE
The candidates and health care

The candidates to become Michigan's first new governor in 14 years share this month's cover. Our special report describes them and their views on health care delivery in Michigan. (Photos courtesy campaign offices.)

MICHIGAN MEDICINE

October 1982, Volume 81, No. 46

Special report

550 How will Michigan's new governor affect health care delivery in Michigan? This month's issue of *Michigan Medicine* attempts to help physicians know the answers to that question. We hope MSMS members thus will be better able to make an informed choice on Nov. 2. This special report provides each candidate's reply to our written questions to determine his views on a number of health care policy questions. In addition, we provide profile features of the candidates, a preview of the election and ballot issues, a description of MDPAC activity leading up to the election and brief biographical sketches of the candidates for lieutenant governor; Kevin A. Kelly and Willah Weddon

Features

563 How to put together a good patient information booklet; another in the series to help Michigan physicians "meet the challenge of the 80's"

567 Here are first data in the most definitive survey to date on Michigan physicians' practice characteristics; Jerry Cromwell, Miron Stano, Joseph Velky and Delores Gelemey

Departments

547 Letters
558 Views; Bailus Walker, PhD, MPH
560 MSMS/A; Cheri Calvelo
574 Financial planning/investment perspectives; Daniel L. Ludwin
579 Medical newsfronts
586 New members
592 News; Sheri W. Greenhoe
594 Meetings
596 Category I courses
600 Deaths
604 Classified ads
605 Ad index
606 President's page; Frank Cox, MD

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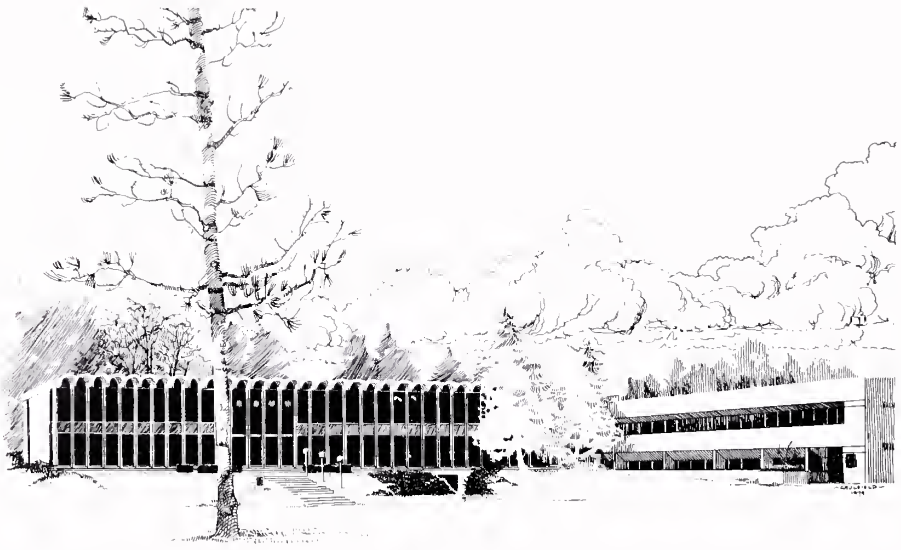

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Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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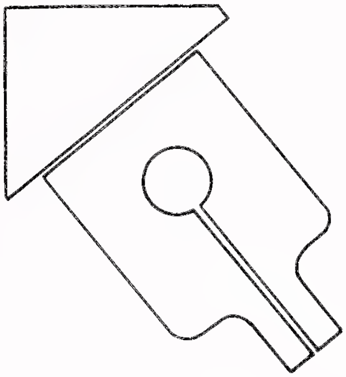
LETTERS



July MM

Your July '82 Special Report was excellent — Doctors Ought to Care, Physicians for Social Responsibility, Medical Group Missions, Downriver Detroit Project Health Care are *positive* projects. I hope you will disseminate this information further. Not to toot anyone's horn — but to show what can and *is* being done, here in Michigan, by these fine people, to be positive to help, and to bring hope into peoples' lives. Keep up the good work!

Christopher M. Thierry, RN
Facilities/Critical Care Coordinator
UP Emergency Medical Services Corporation
Marquette

August MM

I want to commend you for that excellent number of the August *Michigan Medicine!* You hit me right in four areas I am very interested in: the super article and pictures of Mrs. Auberlin, who used to be a neighbor of a patient of mine; the supply of doctors for the U.P. which was always our favourite vacation spot while we practised in Bellaire; the account of the nuclear war symposium (I am a member of PSR); and the one on seat-belt legislation. We have come a long way on that one!

Early in my years as chairman of the MSMS Traffic Safety Committee, I was slated to make a presentation in Washington before a House Committee interested in traffic safety. When GM heard about it, they sent a junior executive up to Traverse City to check me out and I suspect to brain wash me if necessary. We found we were not as far apart as we might have been judged, and I chuckle to remember that he was apologetic over the fact that when he bought his new GM car, he had to go to Montgomery Wards to get his seatbelts!

Incidentally, in my Washington presentation, I urged that the motor car companies get together voluntarily on their safety standards, otherwise there would be no choice but to have federal standards. I think this was about the first gun fired in the battle for federal standards.

Keep up the good work!

John R. Rodger, MD
Kalamazoo

Disabled Physicians

The St. Paul-Ramsey Medical Education and Research Foundation has been actively involved in compiling a resource directory for physicians with physical disability. The purpose of the project is to form a voluntary group of physicians to provide information and referral services as well as support and advocacy to physicians who incur the same disability and need specific information. I became deaf seven years ago just as I was completing medical school and can readily attest to the paucity of information available to this unique population. Existing rehabilitation programs are simply not equipped to deal with the situation.

The biggest problem we are encountering is that of identification. It is currently estimated that four percent of all physicians are not in active practice because of a physically disabling condition, and that 25 percent of the physicians have the potential to be rehabilitated into the active practice of medicine. In real numbers this constitutes 1 percent of the licensed physicians in this country, or 4,500 physicians.

Our goal is to identify these physicians and encourage their participation. To date we have placed advertisements in over 100 major medical journals and have had response from less than 200 physicians. In retrospect, it appears this was due to the use of inappropriate terminology in the ads. Physical disability does not imply inability. My use of the term "handicapped physician" was a misnomer since the majority of physically disabled physicians are not handicapped in their practice of medicine.

I apologize for the inappropriate terminology and again ask that all physicians, active or inactive, with any type of physical disability contact me at St. Paul-Ramsey Medical and Educational Research Foundation, 640 Jackson St., St. Paul, MN 55101.

We anticipate that the directory will be completed in 6-8 months and at that time it will be sent to only those physicians who are listed therein. Upon receipt of your initial response, information forms will be mailed.

All physicians with physical disability, no matter how small, are encouraged to respond. Information from a doctor with even a minor disability may be of value to another doctor with multiple disabilities. The cornerstone of this project is your participation.

Frank C. Zondlo, MD
St. Paul

Continued on page 591

Candidates for nutritional therapy...

10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socio-economic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]

Before prescribing, please consult complete product information, a summary of which follows:
Each Berocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.
Contraindications: Hypersensitivity to any component.
Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
Adverse Reactions: Adverse reactions have been reported with specific vitamins and

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5,000,000 hospital patients with infections.[4] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[3]

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.[5]

Berocca Plus
A balanced formula for prophylactic or therapeutic nutritional supplementation.

Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

Berocca Plus, highly acceptable to patients, has virtually no odor or aftertaste and is economical. And its "Rx only" status means more physician involvement, better patient compliance.

References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.
Dosage and Administration: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.
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candidates for

Rx ONLY **Berocca® Plus** TABLETS

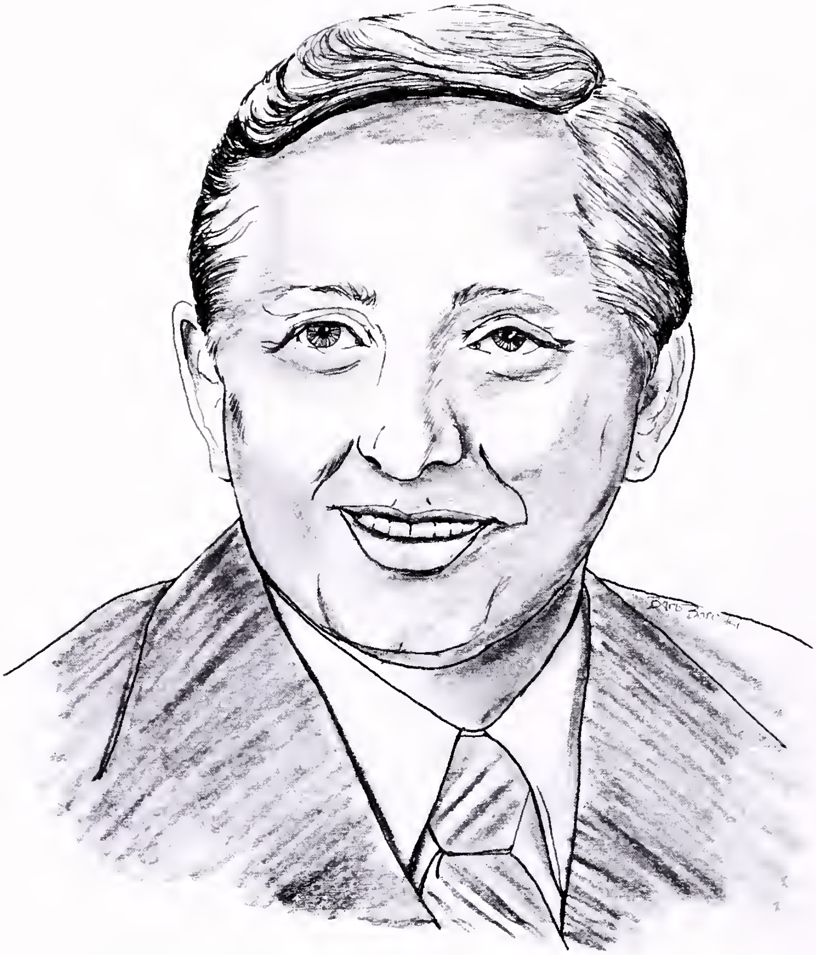
THE MULTIVITAMIN/MINERAL FORMULATION

Making The Choice

How the candidates will affect health care in Michigan

It has been 14 years since Michigan changed governors. That makes the coming Nov. 2 election particularly interesting for physicians and their fellow health care professionals. What will the new governor see as priorities in health care delivery? How will he act on such areas as key appointees, Medicaid financing, Board of Medicine relationships and mental health programs? *Michigan Medicine* asked each of the candidates to write on such subjects, to give MSMS members an informed choice at the polls. One candidate chose to elaborate on each of the questions asked, the other to provide a general statement of principles. Each reply is revealing. We hope you will find them interesting.

Vote Nov. 2!



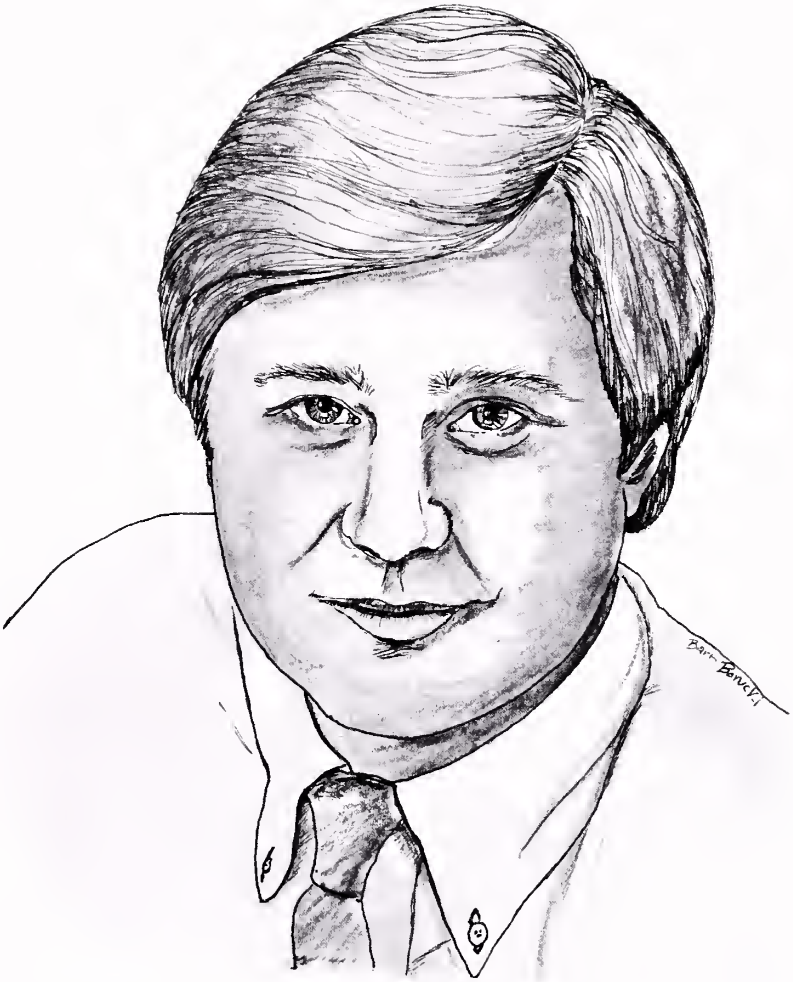
Richard Headlee's view:

Business as usual with big labor or a businessman's approach to better management — that's the choice confronting medical doctors and Michigan voters this November 2. Michigan is a state that needs dramatic overhaul of its operating procedures. Medical doctors participating in the Medicaid program know only too well what the problems are in Lansing. Reduced payments, delayed payments or denied payments have become the rule, not the exception. State government in Michigan is a $10 billion business that would be bankrupt if it were a corporation. I believe that we can, and must, change the practices and policies that have led us to this state of disarray.

When I announced for Governor in February, I stressed that better management of state government would be one of my highest priorities. As a businessman, I would not be allowed to operate my company the way the state has operated in recent years. A key component of my 10-point plan for Michigan's economic recovery is the carrying out of operational audits of all agencies and departments of state government. We need to fully examine all programs and policies. We need to add efficiency where none exists. We need to work fairly and responsibly in cooperation with medical doctors, hospitals and all who contract or do business with this state. We must clearly state the objectives of our programs and work to achieve them with a reduced bureaucracy and reduced paperwork.

One area of particular importance to medical doctors is the future financing of Michigan's Medicaid system. A great debate is underway in the country today over President

Continued on page 556



James Blanchard's view:

I would like to thank the Michigan State Medical Society and the editor and staff of *Michigan Medicine* for this opportunity to communicate with the state's health care professionals. They serve a vital function for the people of our state.

First rate and affordable health care should be available to all of Michigan's citizens, and it is my intention to work closely with the state's health care industry to develop workable approaches to maintain quality care and at the same time keep costs from escalating.

I am committed to effective planning and careful consultation with local communities to see that adequate health care facilities are available and that high standards of care are maintained. At a time when state finances are at a critical stage, and when health care costs have increased at a rate of over 15 percent, state government has a responsibility to take an active role in working with health care professionals to develop reasonable steps to keep costs down State government has an excellent opportunity to pioneer creative ways of reducing health costs in the context of state employee health care plans, and state employee contracts. Creative solutions there could in turn set an example for employers and workers in the private sector in the state.

Seek out physicians

Too often in the past, decisions relating to health care have been made by state government without full consultation with doctors and others in the health care community, or without sufficient notice before a decision is announced. Such practices will not occur when I am Governor. I will listen to the concerns and seek the views of health care professionals long before any policy decisions concerning health care are made, and the state's medical community will not be left in the dark when a policy is announced.

Similarly, in making appointments to policy-making positions in the Department of Public Health and the Department of Mental Health, the recommendations of the medical community will certainly be considered. In the months ahead, it will be critical that the problems confronting our state, including health care issues, are resolved in a spirit of cooperation and consensus — and I will do just that when I am Governor.

In 1982, Michigan finds itself at a crossroads. We are faced with our most serious economic crisis in 50 years. Michigan must begin at once to diversify its economy. Our state needs a strategic investment program, a job training program that works, and a public works and construction program that will put our people back to work.

Physicians' role important

This fall Michigan's voters are being asked which candidate has the background, the proven leadership skills, and the record of success on the tough economic issues that Michigan's next Governor will need. The voters are being asked which candidate has the demonstrated ability to bring business and labor together in a partnership that will have to grow and develop if Michigan is to have a prosperous future. I believe I am that candidate.

The state's medical doctors and other health care professionals have played an important role in making Michigan a truly great state. I will look forward to working with them on the important question of how best to keep health care quality high and costs affordable in the months and years ahead.

About the men:

For the Democratic Party
James J. Blanchard

By Willah Weddon Stockbridge

James J. Blanchard, Democratic candidate for Governor, has a bland smile and an affable personality. He makes few enemies, knows how to manipulate political interests and, with an almost uncanny ability, manages to come out on top in the political jungle.

Born in Ferndale Aug. 8, 1942, Blanchard was raised a Unitarian, in a household where politics were discussed frequently and former President Franklin Delano Roosevelt was a model. By the time he was 10 years old, he was handing out political pamphlets during elections. As a teen-ager his ambition was to become a congressman.

How quickly he achieved his goal came as a surprise even to him. At the age of 29, he was elected to the U.S. House of Representatives in 1974, in his first try for political office. He has been re-elected each term since. During the eight years he's represented the 18th Congressional District (parts of Macomb and Oakland Counties), Blanchard has kept an eye on his constituents' moods. He has modified his outlook, when necessary, to stay in the mainstream.

Early career

Following his graduation from Ferndale High School, Blanchard attended Michigan State University where he received a master's degree in business. He then studied at the University of Minnesota and returned to Michigan with his law degree in 1968. For the next few years he worked in Lansing, first as a legal adviser to the late James Hare, Secretary of State, and then for Michigan's Attorney General Frank Kelley as an assistant attorney general.

While a law student, Blanchard married his MSU sweetheart, Paula Parker from Clarkston. She taught two years in a suburban Minneapolis school system and two more years after the couple returned to Lansing. She retired from teaching when their son, Jay, was born 11 years ago. Paula wasn't surprised when her husband decided to run for a congressional seat from his home district (Ferndale) as he'd talked to her for hours about his political ambitions on their first date in college.

The couple bought a home in Pleasant Ridge in 1972 and Blanchard began a private law practice. He entered a crowded Democratic primary a year later and won the election to oppose Republican incumbent U.S. Representative Robert Huber. Although the district was considered a stronghold of independent voters, he emerged the victor.

During his years in Congress Blanchard continued his membership in the Junior Chamber of Commerce (Jaycees). He was selected as one of the five Outstanding Young Men in Michigan in 1977 and one of the 10 Outstanding Young Men in America in 1978.

While in Congress, Blanchard served on the banking subcommittee, beginning with the time of the New York City financial crises. In 1976 he'd helped write a report predicting a problem for Michigan's Chrysler Corporation and was on top of things as chairman of the House Subcommittee on Economic Stabilization when the fiscal situation came to a head. By December 1979, the bail-out had been accomplished and Blanchard was credited with sponsoring a U.S. loan guarantee saving the company from folding.

Until that time, few out-state Michigan voters had heard of Blanchard and he lacked name recognition beyond the metropolitan Detroit area.

Prime backers

When it came to picking a Democratic candidate for the 1982 gubernatorial race, influential party members opted for Blanchard. This caused considerable consternation among other candidates who had announced early and desperately wanted the party's backing.

Blanchard contends he didn't talk to labor leaders until after he'd made his decision to run for the nomination.

Blanchard won the primary election by 50 percent of the vote in a seven candidate race. Less than three weeks later he'd received official joint endorsements by the state AFL-CIO and UAW for the first time in 14 years.

His program

Using Roosevelt's public works and construction programs as a model, Blanchard proposes to create a state-funded job-creating and job-retraining program to ease unemployment in Michigan. He plans to attract investment into the state and enable existing business to expand by the establishment of a state administered investment bank to attract and match private sector investment. He advocates a "substantial reorganization and scaling back of state government" and changes in the single business tax to help small firms. He favors Medicaid support for coverage of abortions for low income families.

For the Republican Party
Richard H. Headlee

Richard H. Headlee, Republican candidate for Governor, says he always found time "to be a good citizen."

But he wasn't involved in politics until he became an adviser to Gov. George Romney in 1966. He was too busy providing a living for his four sons and five daughters.

Headlee was born in Fort Dodge, Iowa, on May 16, 1930, finished high school in Richfield, Utah, where he met his future wife, Mary. He entered Utah State University and married Mary as soon as she graduated from high school. By the time he obtained his degree in 1953, the couple had two children.

Chamber president

Headlee learned about economics the hard way while in college, working in jobs ranging from a fry cook to a shoe salesman. Upon graduation, he entered the U.S. Army and served three years as a First Lieutenant. In 1956, he joined the Burroughs Corp. He became active in the United States Junior Chamber of Commerce (Jaycees) serving as vice president of governmental affairs (he testified before Congress on "Tax Rate Reform" in 1962). The following year he was elected president of the national organization and traveled throughout the US, Europe and Asia.

The Headlee family moved to Detroit in 1964, headquarters of the Burroughs Corp. It wasn't until then that Headlee became a member of the Mormon Church, although Mary had belonged to the church all her life. (He has since become a leader of the Michigan district.)

In 1965 Headlee began working for Gov. George Romney on a volunteer basis, organizing a successful Christmas gift drive for Michigan servicemen in Viet Nam. A year later he became an adviser to Romney. He served in 1967-68 with the "Romney for President Committee."

Romney moved on to Washington as Secretary of the Department of Housing and Urban Development. Although Headlee was now keenly interested in politics, he again focused his attention on the business world. He was named President of Morbark Industries in Winn, Mich., which was failing. He turned it around and made it profitable.

Four years later Headlee joined the Alexander Hamilton Life Insurance Company of America, which also was failing. Within two years he became president and executive officer of the company, increasing sales tenfold and the number of jobs threefold. It became the largest life insurance company based in Michigan. If elected govenor, he will give up the $160,000 year position he now holds with the company to take the $70,000 post of governor.

Headlee Amendment

Headlee came to the attention of state residents in 1978 when he served as Chairman of Taxpayers United for Tax Limitation which successfully amended the Michigan Constitution. The "Headlee Amendment" placed a constitutional limit on all forms of taxation and government spending in the state. Since 1979, Headlee contends, the amendment has saved property owners in the state more than $400 million in property taxes.

Polished and precise in appearance, forthright in answering questions and exceptionally persuasive, Headlee made a good impression on voters in his primary campaign.

His attack on the state's economic program and references to poor financial planning did not endear him to Governor William Milliken's segment in the Republican party. Neither did his all-out backing of President Ronald Reagan. But his financially conservative philosophy and belief in free enterprise put him solidly in camp with enough party members to win the gubernatorial nomination.

Last year Headlee was named chairman of "Michigan Citizens Supporting the President." He is chairman of the Board of Trustees of Oakland University, a member of Utah State University's President's Roundtable, and was chairman of the Michigan State Chamber of Commerce until he announced his candidacy for governor.

The Headlees live in Farmington Hills today, in a six-bedroom home off I-696, north of Detroit.

Take charge

A non-professional politician, Headlee thinks the fact that he's not held public office previously is one of his greatest assets. Indeed, he won the primary election against three opponents by a margin of 34.3 percent, when each of the others held an elective office.

A dynamic speaker, articulate and intelligent, Headlee says he'll bring "take-charge" leadership" to state government making it more efficient. He'll "get Michigan working again," he says, by unleashing free enterprise.

"Creating new jobs in Michigan is the only hope for the working man," Headlee says. He points out, "You can't have employees if you don't have employers." He also has a definite program in mind to accomplish his objectives. Among these are: registering able-bodied welfare recipients for "work-fare," revising the single business tax, overhauling unemployment and workers' compensation programs to make them less costly to business, auditing state government completely, freezing state government hiring and salaries, and bringing Michigan's welfare benefits down to the levels paid by neighboring states.

SPECIAL REPORT/*Continued*

What's on the ballot?

Here is the ballot wording approved by the Board of State Canvassers for the issues which will appear on the November 2 ballot. Only one is closely related to MSMS actions and that one appears here in detail.

Candidates for the lieutenant governor

Republican

Thomas E. Brennan

Thomas E. Brennan, 53, Lansing, is president of the Thomas M. Cooley Law School which he founded. A Catholic, born and raised in Detroit, Brennan graduated from the University of Detroit in 1952, with a law degree.

During subsequent years the reddish-haired Irishman was a partner in a law firm with James Brickley, Robert Waldron and Raymond Gribbs; elected to Common Pleas Court of Detroit; appointed by Gov. Romney to Circuit Court of Wayne County and served as Circuit Judge from 1963-66, the year he was elected to the State Supreme Court. He resigned from the high court after serving seven years to devote all his time to the fledgling law school he'd started. He has guided it to the highly reputable institution it is today.

Democrat

Martha W. Griffiths

Martha W. Griffiths, 70, Armada, Township in Macomb County, was born in Pierce City, Missouri. She came to Michigan to study law at the University of Michigan and remained here after her graduation in 1940. She practiced law with her husband, served in the State House of Representatives 1949-52; was appointed as Recorder and Judge of Recorder's Court in April 1953; was elected to the U.S. Congress and represented the 17th district from 1954 until her retirement in 1975.

While serving in congress, Griffiths was a member of the House Ways and Means Committee, a sponsor of the national Medicaid program, and instrumental in its passage into law. Considered a feminist leader, she got the Equal Rights Amendment discharged from committee and was active in the ill-fated drive for its adoption.

Proposal A

A proposal to allow the legislature to pass laws to reform their existing constitutional exemption from civil arrest and process during legislative sessions.

Proposal B

A proposal to create by constitution a Michigan Department of State Police, provide for its personnel, prescribe its duties and require minimum staffing.

Proposal C

Proposal to prevent a lender from using a "due-on-sale" clause to foreclose a mortgage or land contract when the property is sold, unless security is impaired.

Proposal D

Proposal to require hearings on all utility rate increases, abolish rate adjustment clauses and establish procedures in rate hearings.

Proposal E

A proposal expressing the people's desire for a mutual nuclear weapons freeze with the Soviet Union and requiring state officials to convey that desire to the president of the United States and other federal officials.

The proposed law would:

1. Establish as a "finding and declaration" the danger of nuclear war and reduction of that danger by a mutual agreement between the USA and USSR to establish nuclear freeze.
2. Require House Clerk and Senate Secretary to send to President and other federal officials a communication urging:
   a. The USA propose to USSR a mutual nuclear weapons freeze, both countries agreeing to halt the testing, production and further deployment of all nuclear weapons, missles, and delivery systems in a way that can be checked and verified by both.
   b. Transfer of nuclear weapons funds to civilan use.

MDPAC makes its strongest bipartisan recommendation: Vote Nov. 2!

By Kevin A. Kelly
East Lansing

"Your support is crucial to the success of my campaign . . ." How frequently we hear that claim!

It is a political fact that it takes a tremendous commitment of human and financial resources to run a successful campaign.

1982 is no exception. It will not be unusual for a candidate for the Michigan House of Representatives to spend from $30,000 to $60,000, and for a candidate for the Michigan Senate to spend from $80,000 to $150,000 on their respective campaigns. With this in mind it is easy to see why it is a candidate's first priority to raise campaign contributions; and why a candidate may possess a long memory for those individuals and groups who give active support.

MDPAC recommends

The Michigan Doctors Political Action Committee is making its final recommendations for candidate support in the Nov. 2 elections. In this year of reapportioned districts, historically large legislative turnover, and the "changing of the guard" in the Governor's office, the Michigan electorate will select 110 members of the house of representatives, 38 state senators, 18 US congressmen, two state supreme court justices, one US senator, and a governor.

Early money is a prerequisite for success in many campaigns. Thus, MDPAC contributed to the campaigns of many candidates prior to the August 10 primaries. In the primary elections, the MDPAC Board of Directors recommended political contributions be made to 63 state house candidates, 15 US congressional candidates, and one US senate candidate. Fifty-nine of the 63, or 93.7 percent of the state house candidates that MDPAC supported were winners: 26 of the 30, or 86.7 percent of the candidates MDPAC supported for state senate.

Under a controversial legislative redistricting plan adopted in May by the Michigan Supreme Court, many incumbents have been forced to run against each other. Many districts were without an incumbent candidate. In the senate there is one district where incumbents will meet head on November 2; in the 14th senate district (Saginaw County) Senator Robert Young (R) will face Senator Jerome Hart (D).

When the 82nd legislative session convenes in January there will be at least 16 new state Senators. The question of control of the Michigan State Senate by either Republicans or Democrats most probably rests on the outcome of the November elections in 6 or 8 swing senate districts. The relative successes of the Blanchard and Headlee campaign will play a major role in producing voter turnout for both Democratic and Republican state senate candidates in those close races.

Of the 110 house of representative districts, 41 are "open seats," where there is no incumbent running in the general election. It appears there will be about 45 freshman legislative representatives when the new house is sworn in.

This has been a particularly satisfying year to MDPAC as many, many physicians have contacted MDPAC and individual members of the board of directors with personal recommendations for candidate support. MDPAC has had the opportunity to meet with small groups of physicians around the state in order to conduct candidate interviews and candidate assessments. Individual physicians also have agreed to lend their names to candidates' letterheads. We have been very effective in setting up a number of "physicians for . . ." candidate support letters. All of those activities have led to the recognition by legislators and their staffs, that yes, physicians have been an active and effective political precinct in 1982!

Political education is a continuing function of MDPAC. This year, Thomas C. Payne, MD, chairman, MDPAC, will speak at the MSMS Public Affairs/Leadership Conference on October 28. Tom Greene, Capitol correspondent for WDIV-TV will join Doctor Payne on the podium as they discuss the 1982 elections. MDPAC, in conjunction with AMPAC, held a political education workshop for the MSMS Auxiliary on September 20. This workshop reviewed the "nuts and bolts" activities of MDPAC and political campaigns.

Campaign contributions through MDPAC enable a candidate to be a strong competitor in the political marketplace until the morning of the election, when the political dialogue of the summer ends, and the political choices of autumn must be made.

Michigan's 12,000 voting physicians and their families constitute a significant political entity — if they do not allow the voting booths to be silent in recording the choices of medicine.

In closing, MDPAC makes its strongest bipartisan recommendation: VOTE, and remember, some of the least admirable of your political neighbors hope you stay home.

Mr. Kelly is the executive director of Michigan Doctors Political Action Committee.

HEADLEE/*Continued*

Reagan's new Federalism program. At least three current proposals in Washington exist to implement the President's program. Each of these would result in complete federalization of the Medicaid program. The advantages of a national standard for Medicaid may be significant to Michigan. Since the cost of Medicaid has been one of the most rapidly increasing areas of the state budget, complete federal assumption of this cost may be considered extremely desirable.

While a federal program would be uniform, a lowering of benefits would create enormous pressure for Michigan to provide other supplemental programs. For valid social and humanitarian reasons, Michigan developed a very generous program of Medicaid benefits. Today the question is whether or not we can afford that program. The short term solution of the legislature has been to reduce the amount the state reimburses for services purchased. This has discouraged participation in the Medicaid program and could ultimately destroy it. My administration will carefully review and rethink our current Medicaid benefit package. I believe that a state policy must be developed based first on economic and fiscal realities. That policy will then determine what Michigan's position will be on the question of federalizing the Medicaid program.

The following are brief comments on some other areas.

1. Budgeting for the Departments of Public and Mental Health

The health care industry in Michigan is important and big business. Health care expenditures play a major role in the state's budget. In 1982, over 23 percent of the state's budget was devoted to health care expenditures. This represents approximately a 35 percent increase since 1978. We will not make decisions while isolated from those most knowledgeable about the provision of such important services and programs.

My first step as Governor would be to complete thorough audits of all departments, including Public and Mental Health. The state must consolidate and coordinate efforts to develop the most effective and efficient programming that is possible.

2. Role of the Board of Medicine and the impact of appointments to the Board

Licensing boards play a crucial role in protecting the public from incompetent or unscrupulous practitioners. This is particularly true for the Board of Medicine and the Board of Osteopathic Medicine and Surgery, because physicians have a greater potential than most professions to do harm to the public. The dedication of the physicians who voluntarily serve on these boards as a service to their state and their profession is recognized and appreciated. As Governor, I would identify and appoint qualified, dedicated men and women to these boards. I think the licensing boards can also serve as advocates for the types of reforms and governmental restructuring that can increase the ability of practitioners to delivery necessary services.

3. Role of labor unions and the delivery of medical care

The labor unions have played a very strong role over the past 40 years in shaping health policy in Michigan. Through ever increasing benefit packages won at the bargaining table and through the use of their considerable political muscle in the legislature, labor unions have shaped much of the philosophy of Michigan's social programs. In the early years the cost of these programs was considered manageable. Today we find ourselves in a situation, both in the public and private sector, where we can no longer afford many of the bargained for, or legislatively mandated, benefits. In the private sector the recent experience of Chrysler Corporation indicates the scope of the problem. In the public sector the legislature has focused on reduced payments to physicians, hospitals, and other health care providers. This short term and in some cases short sighted strategy cannot be confused with any type of long range solution. My administration is committed to a comprehensive review of this problem. I personally am strongly committed to co-payment features as a means of cost containment. Our objective must continue to be affordable, adequate coverage for Michigan's citizens, along with prompt payment for cost effective services.

4. Alternative Delivery Systems

I think that the trend to develop alternative health care delivery systems is a healthy response to an increasingly competitive market. The role of government in this activity is to safeguard the consumer from unscrupulous entrepreneurs without giving a market advantage to any one alternative.

The health care reimbursement system, like all social systems, is in a constant state of evolution. The newly developing health care delivery systems are manifestations of this evolution. Perhaps it is more correct to refer to them as alternative health care reimbursement systems, because the mode of reimbursement seems to change more than the mode of health care delivery. I would propose putting these mechanisms to the true market test by requiring the state, and permitting other third party reimbursers, to adopt the "prudent buyer" concept. This concept means that the state and the third party payors would purchase services from the lowest bidder.

Michigan's health care providers must be good managers to survive in our competitive economy. As taxpayers, you are entitled to good management of our state government and to the efficient and effective use of your tax dollars. I believe that my candidacy offers the best prospect for bringing about necessary changes. I look forward to working with you in 1983 for a better Michigan. I welcome your questions or comments. I may be reached at Headlee for Governor, 320 West Ottawa, Lansing, Michigan 48933.

Here is your last chance to register for the 1982 MSMS Annual Scientific Meeting!

Fill out the form today; do not delay, as courses of your choice may be filling. Send the form and your fees to MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823.

PLEASE SEND ENTIRE PAGE WITH CHECK

1982 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration form for Category I CME Courses

***All courses are approved for AAFP Prescribed Credit *EXCEPT* those marked with an asterisk.**

TUESDAY MORNING, NOV. 9

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Acute Neurological Emergencies
____ Basic Cardiac Life Support
____ Carcinoma of the Breast
____ Emergency Psychiatry for the General Physician
____ Ethical Practice Habits for Healthier Patients
____ Recent Advances in Diagnosis and Management of Cardiovascular Disorders in the Young
____ Stroke 1982: An Update in Current Diagnosis and Treatment
____ Technology Explosion in Obstetrics/Gynecology
____ Your Patient's Respiratory Tract and His Job

TUESDAY AFTERNOON, NOV. 9

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Anti-Substitution: Dangerous Drug Decisions
____ Causes and Prevention of Automobile Crash Related Injuries
____ Common Nephrological Problems
____ Helping the Healer to Get Help
____ Hepatitis — An Update
____ Management of Common Ear and Throat Problems
____ Multiple Sclerosis: Diagnosis, Management, and Research
____ Patient Behavior Can Be Changed
____ Psychiatry for the General Physician

The half-day courses will provide three hours of Category I credit toward the state relicensure requirements and the AMA Physician's Recognition Award.

Please check the courses you wish to attend. In each case, *please indicate a second choice* should the first choice already be filled. Maximum attendance figures have been set for each course because rooms vary in size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk upon arrival at the Hyatt Regency.

Physicians must make their own hotel reservations prior to 10/18/82 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, 313/593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

WEDNESDAY MORNING, NOV. 10

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Aging — Is It Worth It?
____ Basic Cardiac Life Support
____ Dermatology for the Non-Dermatologist
____ Evaluation and Treatment of the Dizzy Patient
____ Foot Problems: Cradle to Grave
____ Medical Treatment of Peptic Ulcer Disease — Bleeding and Non-Bleeding
____ New Aspects of Diagnosis and Treatment of Infectious Diseases
____ Pediatric Endocrinology
*____ Simplified Management of Mechanical Ventilation
____ Victims of Violence

WEDNESDAY AFTERNOON, NOV. 10

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Allergy and Asthma: Diagnosis and Management
____ Basic Aspects of Athletic Injuries and Treatment Approaches in Sports Medicine
____ Dermatological Aspects of Sports Medicine
____ Diagnosis and Conservative Treatment of Neck and Arm Pain
____ Diverticular Disease — Old and New Concepts
____ Medical and Surgical Aspects of Inflammatory Sinus Disease
____ Medical Genetics for the Practicing Physician
____ Pulmonary Function Studies and Arterial Blood Gases
*____ Urinary Incontinence — Evaluation and Treatment

THURSDAY MORNING, NOV. 11

(8:30 to Noon, including break)

(Write 1 in blank for first choice and 2 for second choice)

*____ Congenital Anomalies in Plastic Surgery: Basic Concepts
____ Depression: Modern Concepts in Recognition and Treatment
____ Diabetes — Current Concepts and Update
____ Endocrine Disease and the Eye
____ Ethnicity and Medical Practice: Diagnosis, Treatment & Patient Compliance
*____ Management of Chest Trauma
____ Problems Faced by Surgeons in the Intensive Care Unit Postoperatively
____ What the General Practitioner Needs to Know About Head and Neck Cancer
____ Workshop on Vascular Disease: Diagnosis and Management for the Generalist and Specialist

THURSDAY AFTERNOON, NOV. 11

(1:30 to 5:00, including break)

(Write 1 in blank for first choice and 2 for second choice)

____ Acute and Chronic Back Pain
____ Born Before Their Time: Managing Prematurity
*____ Congenital Anomalies in Plastic Surgery: Specific Reconstruction Procedures
____ Gout, Pseudogout and other Crystalline Deposition Syndromes
____ Medical Ethics: Clinical Determination of Mental Capacity
____ Nuclear Cardiology: Uses in Clinical Practice
____ Pediatric Ultrasound — How You Can Effectively Use it in Practice
____ Psychotherapy by the Primary Physician Psychoanalyst Team
*____ The Current Technological Parade in Management of Eye Diseases

- -

Name ____
(please print) (first) (initial) (last)

Street ____

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MSMS Member: Yes ____ No ____ Resident ____ Specialty ____ Other ______

Tuition Schedule for courses:

MSMS members: $6 per credit hour, or $18 for each half-day course
MSMS members with "retired status" pay half the regular course fee
Non-members: $12 per credit hour, or $36 for each half-day course
Residents: $5 PER COURSE (Does Not Include Lunch)

A deli sandwich lunch will be provided at no extra charge. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

- Tuesday lunch ______ Wednesday lunch ______ Thursday lunch ______
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Preventive medicine needs community coordination

By Bailus Walker, PhD, MPH
Lansing

Doctor Walker is director, Michigan Department of Public Health. This is the second in a series of articles which he will contribute to *Michigan Medicine* on the subject of environmental health.

Perhaps Edward Brandt, assistant secretary of health, said it best. I can do no better than to quote him: "Prevention has become an integral part of the fabric of health and medical care in the United States. And none too soon."

The burdens of illness — whether expressed in personal, family or fiscal terms — are becoming too great to bear, not just for individuals, but for society as a whole.

The economics of promotion and prevention argue powerfully for spending more on such health services. Fifty cents spent educating a child to the hazards of cigarette smoking can save thousands of dollars which might otherwise be spent attempting to arrest lung cancer 40 years later.

Competing claims

Although the economic case for promotion and prevention is clear enough, the argument will continue to face a world of competing claims. The plain truth is that the individual citizen, the single taxpayer, is hard pressed to consider his economic and health interests much beyond the next pain or the next proposal to boost the tax rate.

Knowing the facts, however, does not relieve the private and the public health sectors of their obligation to seek a more rational set of priorities for allocating health resources. If anything, it places squarely on our shoulders the major burden for continuing the fight to get more health resources allocted to health promotion and disease prevention.

During an era in which public concern is focused on the cost of medical care, on bed reduction, or on the licensure of the CT Scanner and other modern diagnostic and therapeutic technology, there is some danger that public health organizations and private practitioners of medicine will overlook our responsibility — in fact, our duty to act as the chief advocates of health promotion and disease prevention.

Ending fragmentation

High on our agenda for action programs is elimination of the fragmentation of health services. The continuing separation of the mind from the body — mental health from public health; the child from the adult — in much of the present day health administration has, of course, the sanctions of history. But it shows little wisdom or logic. Inappropriate vested interests in public health are no less difficult to obliterate than they are in any other human endeavor.

A similar fragmentation is evident in the control of occupational and nonoccupational hazards to human health. Unlike communicable disease control where the individual with tuberculosis or other infectious disease is a threat to the community, in environmental health it is the community which threatens the individual. It threatens through the production, use and disposal of toxic substances, air pollution and many sources of radiation.

Thus, multiple causation is one of the most distinctive characteristics of environmental health and prevention of environmentally-induced diseases requiring a coordinated approach — one that includes history, business, labor and government. This coalition must be formed as quickly as possible, leaving aside past overt and covert adversarial interactions.

State government must use its resources to encourage active programs of promotion and prevention. Substantial influence can be exerted by the human services agencies through their many channels to individuals and groups. We shall urge such action by the Governor's human services cabinet.

Intensifying efforts

The Michigan Department of Public Health, along with many other health agencies and organizations, will intensify its efforts to ensure that health care providers are kept informed about developments in the state affecting health promotion and disease prevention.

We already have reorganized the Department, establishing a major subdivision, the Health Promotion and Disease Prevention Administration, which has a leadership role in carrying out our commitment to give the highest priority to promotion/prevention services. We also have combined previously fragmented programs in communications and health education in response to the growing demand on the part of consumers for more and better health information.

It is my conviction that no single element or uncoordinated group among Michigan's health resources can match performance with potential — can close the gap between what is known and what is applied — in promotion and preventive health services.

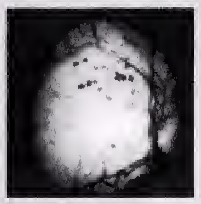
The task calls for a coordinated attack, community by community, in which the health-medical profession plays a critical role.

WE HAVE A SOLUTION FOR A DIFFICULT UROLOGICAL PROBLEM

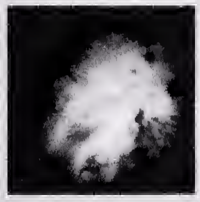
The Problem

SYMPTOMS:

EARLY
INTERSTITIAL
CYSTITIS



CLASSICAL
INTERSTITIAL
CYSTITIS

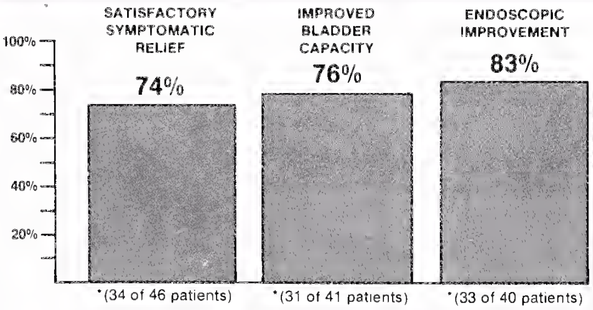


- ☐ irritative voiding symptoms
- ☐ suprapubic pain
- ☐ functional bladder capacity reduced
- ☐ anatomical bladder capacity:
  - EARLY — normal
  - CLASSICAL — reduced
- ☐ vesical mucosa:
  - EARLY — normal appearing
  - CLASSICAL — ulcerated, scarred
- ☐ submucosal vesical hemorrhages observed following second overdistension

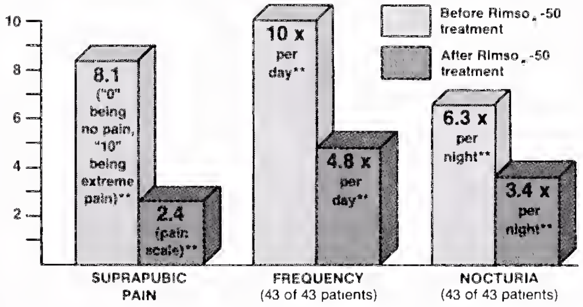
DIAGNOSIS: INTERSTITIAL CYSTITIS

The Solution

Rimso®-50
brand of
STERILE AND PYROGEN-FREE DIMETHYL SULFOXIDE



*STEWART, B.H., et al., *J. Urol.*, 36:116, 1976



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Rimso®-50
(dimethyl sulfoxide)
50% w/w aqueous solution

INDICATIONS AND USAGE: Rimso®-50 (dimethyl sulfoxide) is indicated for the symptomatic relief of patients with interstitial cystitis. Rimso®-50 has not been approved as being safe and effective for any other indication. There is no clinical evidence of effectiveness of dimethyl sulfoxide in the treatment of bacterial infections of the urinary tract.

CONTRAINDICATIONS: None known.

WARNINGS: Dimethyl sulfoxide can initiate the liberation of histamine and there has been occasional hypersensitivity reaction with topical administration of dimethyl sulfoxide. This hypersensitivity has been reported in one patient receiving intravesical Rimso®-50. The physician should be cognizant of this possibility in prescribing Rimso®-50. If anaphylactoid symptoms develop, appropriate therapy should be instituted.

PRECAUTIONS: Changes in the refractive index and lens opacities have been seen in monkeys, dogs and rabbits given high doses of dimethyl sulfoxide chronically. Since lens changes were noted in animals, full eye evaluations, including slit lamp examinations, are recommended prior to and periodically during treatment. Approximately every six months patients receiving dimethyl sulfoxide should have a biochemical screening, particularly liver and renal function tests, and complete blood count.

Intravesical instillation of Rimso®-50 may be harmful to patients with urinary tract malignancy because of dimethyl sulfoxide-induced vasodilation. Some data indicate that dimethyl sulfoxide potentiates other concomitantly administered medications.

Pregnancy Category C. Dimethyl sulfoxide caused teratogenic responses in hamsters, rats, and mice when administered intraperitoneally at high doses (2.5-12 gm/kg). Oral or topical doses of dimethyl sulfoxide did not cause problems of reproduction in rats, mice and hamsters. Topical doses (5 gm/kg first two days, then 2.5 gm/kg - last eight days) produced terata in rabbits, but in another study, topical doses of 1.1 gm/kg days 3 through 16 of gestation failed to produce any abnormalities. There are no adequate and well controlled studies in pregnant women. Dimethyl sulfoxide should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when dimethyl sulfoxide is administered to a nursing woman.

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: A garlic-like taste may be noted by the patient within a few minutes after instillation of Rimso®-50 (dimethyl sulfoxide). This taste may last several hours and because of the presence of metabolites, an odor on the breath and skin may remain for 72 hours.

Transient chemical cystitis has been noted following instillation of dimethyl sulfoxide. The patient may experience moderately severe discomfort on administration. Usually this becomes less prominent with repeated administration.

DOSAGE AND ADMINISTRATION: Instillation of 50 ml of Rimso®-50 (dimethyl sulfoxide) directly into the bladder may be accomplished by catheter or asepto syringe and allowed to remain for 15 minutes. Application of an analgesic lubricant gel such as lidocaine jelly to the urethra is suggested prior to insertion of the catheter to avoid spasm. The medication is expelled by spontaneous voiding. It is recommended that the treatment be repeated every two weeks until maximum symptomatic relief is obtained. Thereafter, time intervals between therapy may be increased appropriately.

Administration of oral analgesic medication or suppositories containing belladonna and opium prior to the instillation of Rimso®-50 can reduce bladder spasm.

In patients with severe interstitial cystitis with very sensitive bladders, the initial treatment, and possibly the second and third (depending on patient response) should be done under anesthesia. (Saddle block has been suggested).

HOW SUPPLIED:

Bottles contain 50 ml of sterile and pyrogen-free Rimso®-50 (50% w/w dimethyl sulfoxide aqueous solution).

Dimethyl sulfoxide is clear and colorless.

Protect from strong light.

Store at room temperature (15° to 30° C).

Do not autoclave.

NDC #0433-0433-05.

*Stewart, B.H., et al., *J. Urol.*, 36:116, 1976

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Rimso®-100

brand of
STERILE AND PYROGEN-FREE DIMETHYL SULFOXIDE

CRYOPRESERVATIVE SOLUTION
(99.0 + concentration)

Available in:

- 10 ml ampules, 10 ampules/case
- 70 ml bottles, 6 bottles/case
- 70 ml multi-dose containers, 6 bottles/case

"Coalitions: Getting together to get things done!"

By Cheri Calvelo
Jackson

The MSMS Auxiliary is excited about being involved in two current health care coalitions. A coalition is the temporary alliance of organizations formed to accomplish a specific goal.

Coalitions are being formed in individual communities, states, and nationwide to deal more effectively with health care concerns. Each organization may provide a unique asset or assets. For example, one may provide volunteer workers, another funds, still another a place to conduct meetings, or provide services such as copying facilities, telephone, or bookkeeping services. When these organizations come together with their special contributions, a powerhouse is formed. Coalitions have the ability to magnify individual efforts, accomplishing more in a shorter period of time.

The concept of working in a coalition might not be an easy one to accept at first, as an organization or group may be fearful of losing its identity or image when involved with others. By setting certain ground rules at the beginning, this can be avoided.

Who speaks?

The first decision that needs to be made, is which organization will speak for the group. Sharing the leadership responsibilities is a plus. Other decisions that need to be made are how credit for the project will be given, how press releases will be handled, and what statements will be made by the coalition as a whole. Sometimes a particular issue cannot be dealt with in a coalition because of lack of agreement. All organizations must agree on what the coalition represents as a whole.

Compromise is sometimes the answer. A decision has to be made as to what the end result of the coalition should be. If the best chance for a successful project means resolution of differences, then they must be dealt with. In a coalition, the organizations become bonded to accomplish something. Together they can give strength to the project.

When the project has been completed, the coalition needs to be dissolved. Coalitions are formed to deal with a specific issue. The same organizations may not be able to deal with other issues effectively. Each organization plays a unique role, and needs to be evaluated as to the possible contribution it may add to a specific coalition.

Seat belts, Medicare

MSMS Auxilians are involved in the Michigan Coalition for Safety Belt Use and feel it is a most worthwhile cause, as lives can be saved and injuries prevented. We are proud that Robert Burton, MD, vice speaker of the MSMS House of Delegates, was elected chairman of this Coalition. It is impressive that over 60 organizations now are a part of this coalition, and it is still growing. Even if legislation is not passed, public awareness of this health threat may make a difference.

The Auxiliary also has formed a coalition with the Michigan Association of Hospital Auxiliaries, to offer Medicare seminars to senior citizens. These seminars help educate individuals about the Medicare structure, such as terminology, deductibles, assignment options, process when check arrives, and repayment procedures. Participants in these seminars also include Michigan Blue Cross/ Blue Shield, Michigan Association of Medical Assistants, and the Social Security Administration (local offices).

Coalitions appear to be the answer to enhance efforts in the area of health care concerns. The Michigan State Medical Society Auxiliary is involved!!

Mrs. Calvelo is president of the MSMS Auxiliary.

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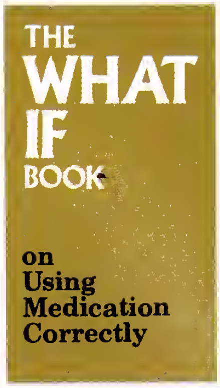
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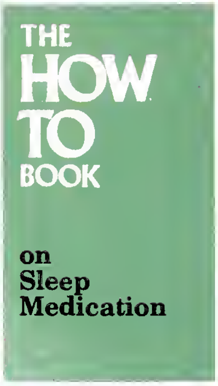
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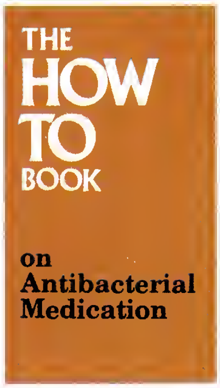
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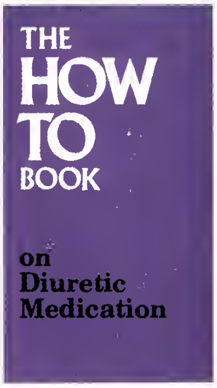
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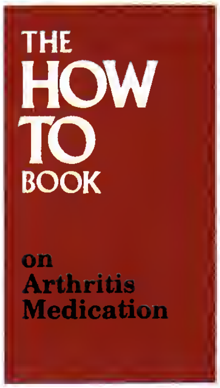
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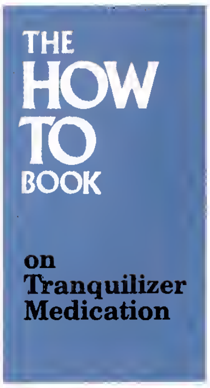
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Patient information folder big step toward good relationship

The most effective means to advise patients of important details about your service is a folder which explains how your office operates and how the patient can make use of your services.

Such folders can be available to patients as they leave your office, or can be presented to new patients as they arrive for appointments.

In addition to advising the patient, the folder gives evidence that the doctor and staff want to help the patient benefit fully in the relationship. It demonstrates the doctor's concern for the patient's need for knowledge of this variety. A folder also offers opportunity for a doctor to list his/her credentials, experience, background and specialty, if desirable.

Creating a folder is not a difficult task. Several such folders already are in use and can serve as models. They need not be expensive to be well done. They can save time for the doctor and staff.

Here is an outline of information which could be supplied in a folder. It might be advisable to vary portions, either by deletions or additions. The important thing is to start preparing, and that's the hardest part. Once the project begins to take form, it flows along with little effort.

Outline for folder to supply patients information

Introduction

Explain purpose of folder

Give evidence of your concern for patients' needs.

Access to doctor and staff

Spell out the best way to contact your office for appointments during regular hours. List regular hours each day and indentify days or other periods when you are away routinely.

Explain how patient can secure medical attention during other hours.

- ✓ Use of answering services.
- ✓ Doctor "trade off" for evenings, holidays, vacations.
- ✓ Office policy for shots, routine physicals.

Use of telephone for prescription renewals, laboratory test results, insurance information. No diagnosis via telephone.

Payment policies

When payment is due.

Insurance arrangements or credit cards

Unusual patient circumstances

Collection methods.

Office operating policies

Laboratory tests and x-rays

Hospital scheduling

Consultation and referrals

Patient records (and confidentiality)

Doctor and staff background

Area of practice or specialty

Area of training

Degrees held

Professional organizations

Philosophy of providing medical service

This information is important, as a patient who understands what is available to him/her as well as what is expected is a more relaxed, better informed person who can feel more confidence in the relationship.

The folder also saves infinite amounts of time and talking for members of the staff, as well as for the doctor.

Folders need not be elaborate.

Most doctor's offices are located within a short distance of one or more printers. The new "speedy" type printing offices often can offer substantial aid in laying out the folder. Most also can offer a modest supply of art which can make a doctor's folder a little more appealing to the eye. A variety of color in paper and ink is available, and it is recommended that thought be given to using a shade of green, blue, buff, or other shade which will permit the folder to be easily distinguished from other papers which might be common in a patient's home, desk, purse or file.

A well planned, neatly produced folder which supplies information a doctor wants his patient to understand constitutes a great step toward developing and maintaining a fine relationship between doctor and staff and the patients.

This article is a sample selection from the developing MSMS manual, "Meeting the Challenge of the 80's," which will be available to MSMS members in December. Major sections of the manual will deal with practice management, communications, ethics and competition. The manual is the project of the MSMS Committee on Public Service, chaired by Robert D. Burton, MD, Grand Rapids. Excerpts will appear in Michigan Medicine *throughout 1982. They are designed to be removed from the magazine and saved for reference until the entire manual is available.*

You may design own folder with these layout sketches

An artist's layout provides a plan for a brochure a doctor may use when discussing details with a printer.

It is necessary for each doctor to specify clearly the details of his/her practice so that the patient will have the best possible understanding of the relationship.

Information utilized by one group of doctors appears here as a sample. It can be changed or adapted to suit the needs of most physicians and their patients.

Once appropriate wording is decided upon, it is a simple matter for a printer to produce a fine brochure.

In discussions with the printer, give thought to the most desirable color of ink and paper; weight of the paper and the number of brochures which will be needed. In general, once the brochure is ready to print, it costs very little more to order an additional 500 or 1,000 copies.

Should somewhat more space be needed to supply all the pertinent information, it is a simple matter for the printer to adapt this layout to a slightly larger size which also will fit into a business size envelope.

Miniature glossary of printing and layout terms

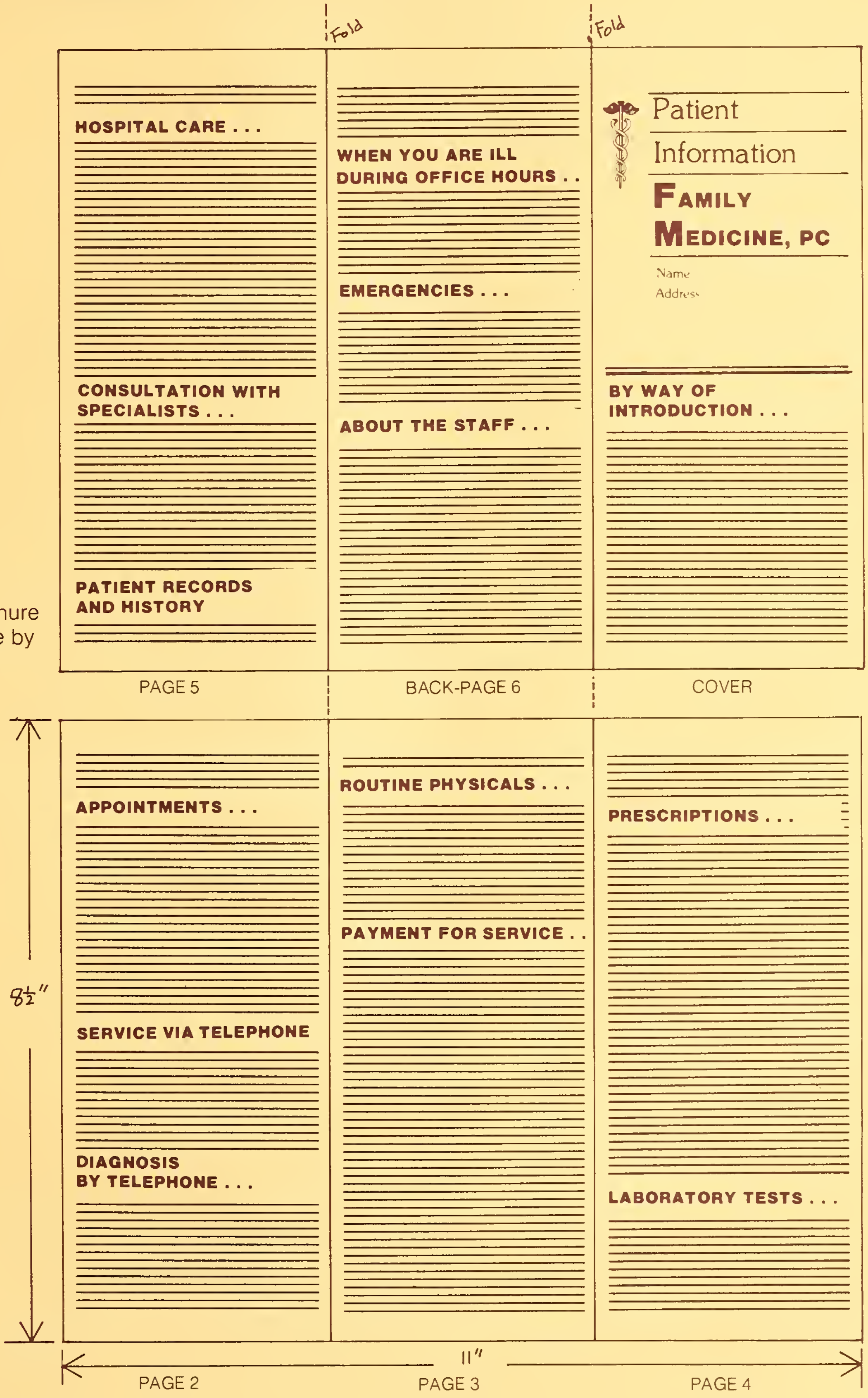
Copy — The typewritten word prepared for setting into type. This term covers everything, including type, illustrations (art), borders, etc., that will be photographed to make the printing plate.

Camera-ready — All copy is in final form, ready to be photographed to produce plates. Headlines, text and art are proofread and corrected, original art is supplied for good reproduction, and all materials are in correct places on pasteup. This also is the term for the camera-ready material.

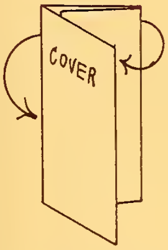
Art — Just about anything not set in type. This includes pictures, sketches, drawings, photographs, cartoons.

Pasteup — The type, art, all the components of the work, as it is pasted in the proper position in preparation for printing.

Proof — This is what a printer supplies to his customer when the pasteup is ready for printing, but before any printing takes place. The customer is expected to check everything completely and approve. Once approval is given, responsibility for errors, if any are discovered later, is the customer's. If such a situation develops, talk it over with the printer.


Fold
Fold
HOSPITAL CARE . . .
CONSULTATION WITH SPECIALISTS . . .
PATIENT RECORDS AND HISTORY
WHEN YOU ARE ILL DURING OFFICE HOURS . .
EMERGENCIES . . .
ABOUT THE STAFF . . .
Patient
Information
FAMILY
MEDICINE, PC
Name
Address
BY WAY OF INTRODUCTION . . .
PAGE 5
BACK-PAGE 6
COVER
APPOINTMENTS . . .
SERVICE VIA TELEPHONE
DIAGNOSIS BY TELEPHONE . . .
ROUTINE PHYSICALS . . .
PAYMENT FOR SERVICE . .
PRESCRIPTIONS . . .
LABORATORY TESTS . . .
8½"
11"
PAGE 2
PAGE 3
PAGE 4

How the six-page brochure would be laid out, page by page.



How the brochure would fold.

Survey of Michigan physicians' practice characteristics

By Jerry Cromwell
Miron Stano
Joseph Velky
Dolores Gelemey
Detroit

Editors's note: This is the first of a series of articles planned by the authors to delineate Michigan physicians' economic practice characteristics. The survey was done under contract by Blue Cross Blue Shield of Michigan for the Health Care Financing Administration. This is the first time a survey of this type has been done to construct an economic model of physicians' office practices in Michigan.

In September, 1981, 12,500 questionnaires were mailed to Michigan physicians (MDs and DOs), including any physician who submitted claims to Blue Cross and Blue Shield of Michigan over a one year period beginning September 1980. The questionnaire was designed to collect information on physician and practice characteristics (including workloads, access, fees, and their patients' insurance coverage) to complement a government-funded study of physician competition in Michigan. The response rate was approximately 17 percent (over 2,100 physicians). This article presents information on 2,070 physicians.

To determine interarea variations in patient access to, and content of, physician services, the 83 Michigan counties were first aggregated into 15 market areas. These areas are identified by their primary county or city and ranked according to physicians per capita in the accompanying tables, with Oakland having the most and the Bay market area the fewest.

Table 1 presents the distribution of responses by market area and specialty. The Oakland the Wayne markets together represent 42.1 percent of all physicians responding to the questionnaire, which follows the overall distribution of physicians. Moreover, specialty mix is obviously quite different across areas with specialists more prevalent in physician-dense localities.

Physician characteristics (besides specialty) are shown in **Table 2**. There are significant differences across market areas in the percent of foreign medical graduates (FMGs) practicing medicine. Thirty-two percent of Berrien area physicians were FMGs compared to only three percent in the Emmett area, although sample sizes are quite small in these localities. Board certification rates very systematically with specialty mix, as expected, while physicians with faculty appointments vary across the state from a high of 41 to 44 percent in the Kent and Washtenaw market areas to a low of four percent in both Bay and Berrien.

Turning to patient access measures, **Table 3** indicates that 68 percent of all physicians are accepting new patients, on average, with no distinct variation between urban and rural aras. Fully 81 percent of general surgeons are accepting new patients compared to only 62 percent of internists. Waits for appointment appear longest in the Kalamazoo and Muskegon areas, averaging about 10 days for new patients. By contrast, new patients in Pontiac or the Upper Peninsula have to wait just over a week. Finally, physicians practicing in areas like Pontiac, Ann Arbor, and Detroit are more likely to see patients on the weekends. General practitioners appear particularly accessible to patients on weekends, as well as during the week, as evidenced by their very short appointment waits.

In physician-abundant areas, one would expect longer visits with the physician. This does appear to be the case although specialty differences can explain some of the trend shown in **Table 4.** Costs-of-practice also are higher in more expensive urban areas, with nonphysician wages per visit ranging from a high of $3.87 in Lansing to only $1.03 in St. Joseph. Wage variations undoubtedly contribute to the variation in fees across urban and rural parts of the state.

Data on workload by market area also was studied. Where physicians are plentiful, we expect workloads to be lighter. Average weekly office visits ranged from 90 to 100 in Marquette and Bay City to a low of 66 in Lansing and Ann Arbor, with most of the difference reflected in office activity. Nevertheless, even hospital activity per physician appears greater in the more rural areas in spite of a much smaller number of hospitalizations. No pattern was found for the average weekly hours (seeing patients) across the market areas.

Insurance coverage data revealed this: Patients with no insurance are more commonly found in rural areas, with Marquette a notable example. Medicaid patients are distributed

The authors are, respectively, president, Health Economics Research, Inc.; associate professor, School of Economics and Management, Oakland University; manager, Health Care Research, Blue Cross and Blue Shield of Michigan; and research associate, Health Care Research, Blue Cross and Blue Shield of Michigan.

Please turn the page for explanatory charts and tables.

Table 1
DISTRIBUTION OF RESPONSE BY SPECIALTY AND MARKET AREA

Market Area	GP&FP	IM	OB/GYN	G.S.	Other Med.	Other Surg.	Misc.	Mich. Total	Total No.
Oakland (Pontiac)	18.7%	21.5%	13.6%	6.5%	8.8%	14.3%	16.6%	20.9%	433
Grand Traverse (Traverse City)	44.6	12.5	7.1	8.9	1.8	16.1	8.9	2.7	56
Ingham (Lansing)	28.2	17.9	8.6	10.3	12.8	12.8	9.4	5.7	117
Washtenaw (Ann Arbor)	23.0	14.2	10.8	4.1	5.4	10.8	31.8	7.1	148
Wayne (Detroit)	34.2	18.2	11.8	11.6	4.8	8.7	10.7	21.2	439
Muskegon (Muskegon)	46.2	15.4	5.1	12.8	0.0	12.8	7.7	1.9	39
Kalamazoo (Kalamazoo)	32.8	16.4	14.2	9.7	7.5	10.4	9.0	6.5	134
Genesee (Flint)	35.2	10.2	7.8	15.6	7.8	11.7	11.7	6.2	128
Emmett (Petoskey)	37.5	6.3	6.3	25.0	6.3	12.5	6.3	1.5	32
Berrien (St. Joseph)	21.4	10.7	21.4	7.1	7.1	17.9	14.3	1.4	28
Kent (Grand Rapids)	33.7	10.2	15.8	10.7	4.1	14.3	11.2	9.5	196
Saginaw (Saginaw)	47.5	10.1	3.0	12.1	2.0	13.1	12.1	4.8	99
Macomb (Mt. Clemens)	28.2	19.8	12.2	11.5	10.7	10.0	7.6	6.3	131
Marquette (Marquette)	43.2	13.6	4.5	15.9	2.3	9.1	11.4	2.1	44
Bay (Bay City)	45.7	13.0	4.3	17.4	2.2	13.0	4.3	2.2	46
Michigan Totals	30.8	16.2	11.3	10.3	6.4	11.9	13.0	100.0	2,070

PRACTICE CHARACTERISTICS/*Continued*

even more unequally, ranging from a low of 10 percent in Ann Arbor to nearly one out of four in the Emmett and Berrien market areas.

How good are patients in paying their out-of-pocket bills? Physicians in our survey reported that patients pay about 65 percent of their copayments on average, ranging from a low of only 51 percent in Detroit to nearly 80 percent in Traverse City. From the uninsured, physicians collect about 87 and 79 percent on an office fee and typical surgical procedure, respectively.

Table 2
PHYSICIAN CHARACTERISTICS BY MARKET AREA

Market Area	Percent Foreign Medical Grad.	Years of Experience	Percent Board Certified	Percent Faculty Members	Percent in Group Practice
Oakland (Pontiac)	21%	20	72.2%	31%	34%
Grand Traverse (Traverse City)	5	17	53.6	13	35
Ingham (Lansing)	5	22	75.2	61	47
Washtenaw (Ann Arbor)	15	18	66.2	41	27
Wayne (Detroit)	23	24	58.0	28	33
Muskegon (Muskegon)	5	18	74.4	6	31
Kalamazoo (Kalamazoo)	13	23	65.7	28	35
Genesee (Flint)	22	23	58.9	43	22
Emmett (Petoskey)	3	18	54.8	13	48
Berrien (St. Joseph)	32	25	59.3	4	39
Kent (Grand Rapids)	7	20	63.0	44	47
Saginaw (Saginaw)	16	24	66.0	36	24
Macomb (Mt. Clemens)	26	21	66.4	26	33
Marquette (Marquette)	7	18	67.4	25	27
Bay (Bay City)	17	21	45.7	4	24
MICHIGAN TOTAL	17%	22	64.5%	32%	34%

Continued on page 572

Laboratory Facilities: Advance Medical & Research Center, Inc. laboratory services and operations have been designed to meet the growing needs of Michigan's medical community. In addition to our main laboratory, located in Pontiac, we have client service centers and branch laboratories in most major outstate communities.

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Serving the medical profession since 1963

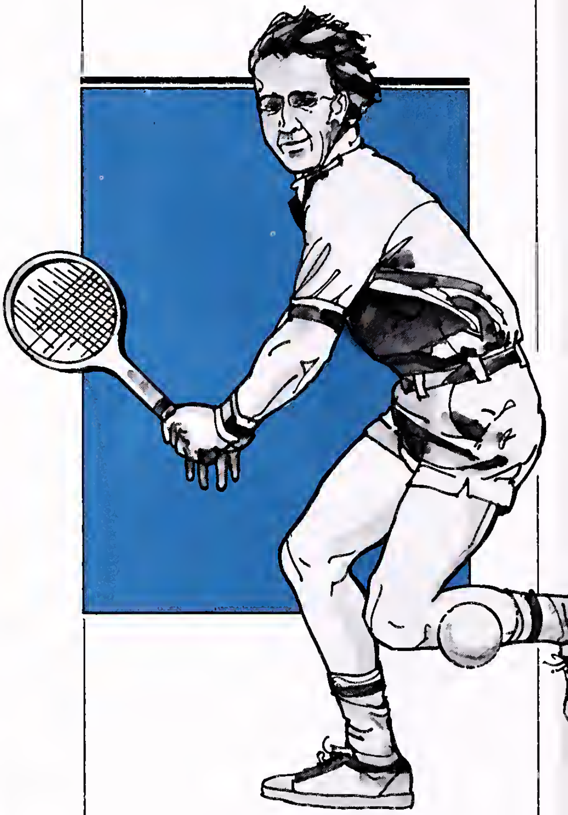
①

More Tips from the Pros.

Balance of power

One of the most important, and most overlooked, keys to ground-stroke strength is balance. Don't lean too far forward or backward when making contact with the ball. And, surprising as it may seem, keeping your head stationary while tracking an approaching ball is a critical factor.

Get your racket back early while following the trajectory of your opponents shots with your eyes…not your head. Because when you move your head to follow a ball, you're adding another motion to your stroking routine that can really throw off your balance and timing.



Plugged lies in the bunker.

If your ball has buried itself in the sand, a normal explosion shot will usually not suffice. A sand iron may not be the right club.

The flange of a sand iron is such that the club will slide through the sand… rather than digging in. You should switch to a pitching wedge because the flange is smaller so that the leading edge digs into the sand and pops the ball out.

Play the ball back toward your back foot. With the club hooded, lift the club straight up with your hands and arms and swing straight down at the edge of the crater behind the ball. The impact will push sand into the back of the ball and cause it to pop out onto the green. You'll get no backspin with this shot so allow for plenty of roll.

CBC… A perfect score

When you select a clinical laboratory, you should automatically consider their record of testing accuracy, the speed of testing results, the conveniences they offer …and, in the midst of today's medical complexities, you should also question the scope of their services.

Sending specimens or patients to different labs for different types of tests can produce a confusing web of information and paperwork for you.

CBC is a laboratory service combining departments of General Chemistry, Special Chemistry, Diagnostic Immunology, Toxicology, Radioimmunoassay, Microbiology, Parasitology, Hematology, Serology, Cytology and Histopathology.

We perform all routine procedures as well as many specialized tests others may have to send out.

Our primary objective is to extend to you the quality of the clinical laboratory ...in accuracy, speed, convenience, and comprehensive services.

We invite you to try us for five free SMA-25 c̄ CBC profiles. And, incidentally, you could win an all expenses paid trip for two to the 1983 U.S. Open Golf or Tennis Tournament—your choice.

Free testing. Free tickets.

We invite you to test our quality and service. Just return this coupon and you'll receive, with no obligation or purchase required, five (5) free SMA-25 profiles c̄ CBC...and you'll be automatically entered in our contest to win a trip for two valued at $2,000 to the 1983 U.S. Open Golf or Tennis Tournament—your choice. No strings attached. Start planning now for this exciting vacation.

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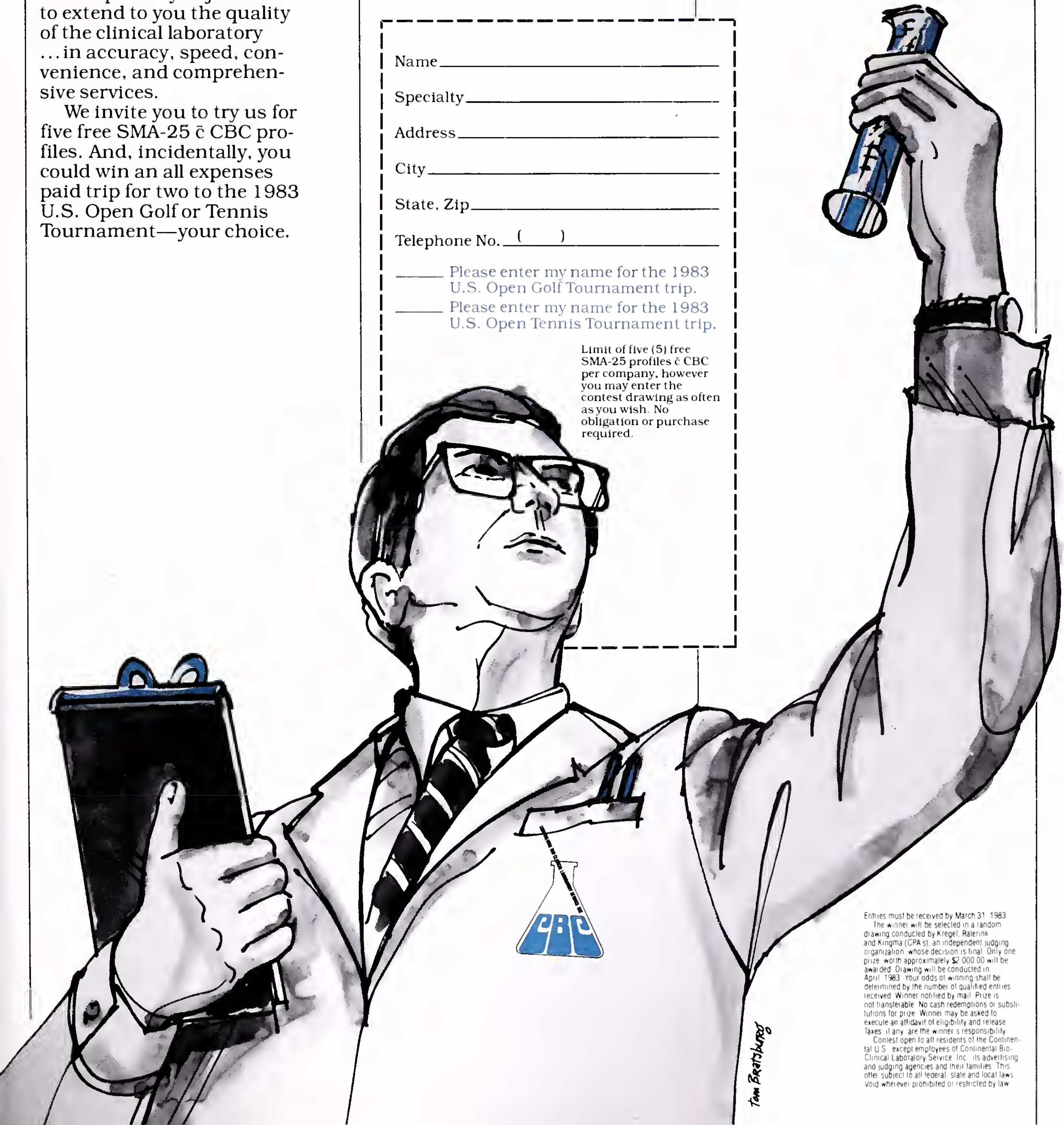
______ Please enter my name for the 1983 U.S. Open Golf Tournament trip.

______ Please enter my name for the 1983 U.S. Open Tennis Tournament trip.

Limit of five (5) free SMA-25 profiles c̄ CBC per company, however you may enter the contest drawing as often as you wish. No obligation or purchase required.



Entries must be received by March 31, 1983.

The winner will be selected in a random drawing conducted by Kregel, Raterink and Kingma (CPA's), an independent judging organization, whose decision is final. Only one prize, worth approximately $2,000.00 will be awarded. Drawing will be conducted in April, 1983. Your odds of winning shall be determined by the number of qualified entries received. Winner notified by mail. Prize is not transferable. No cash redemptions or substitutions for prize. Winner may be asked to execute an affidavit of eligibility and release. Taxes, if any, are the winner's responsibility.

Contest open to all residents of the Continental U.S., except employees of Continental Bio-Clinical Laboratory Service, Inc., its advertising and judging agencies and their families. This offer subject to all federal, state and local laws. Void wherever prohibited or restricted by law.

Table 3
ACCESS TO PHYSICIAN CARE (BY MARKET AREA AND SPECIALTY)

Rank	Market Area	Percent Accepting New Patients	Percent Working Weekend House*	Average Phone Consults	Nursing Home and House Call Visits	Waiting Times (in days) Old Patients	Waiting Times (in days) New Patients	Percent Travel Time ½ Hour +
1	Oakland (Pontiac)	75%	46%	8.5	2.2	3.6	5.9	21.8%
2	Grand Traverse (Traverse City)	75	35	7.7	6.0	4.4	4.7	32.1
3	Ingham (Lansing)	63	26	6.8	1.0	4.7	8.5	22.0
4	Washtenaw (Ann Arbor)	56	41	6.0	1.3	6.2	9.5	18.0
5	Wayne (Detroit)	67	42	7.9	1.8	3.2	6.1	23.9
6	Muskegon (Muskegon)	59	34	7.6	2.8	4.1	9.9	8.6
7	Kalamazoo (Kalamazoo)	56	31	8.1	2.0	6.4	10.4	10.3
8	Genesee (Flint)	63	26	8.7	1.5	3.1	4.9	16.0
9	Emmett (Petoskey)	87	35	7.1	6.4	7.3	9.2	40.0
10	Berrien (St. Joseph)	64	30	6.5	6.0	4.9	9.6	7.7
11	Kent (Grand Rapids)	68	34	7.9	3.8	5.2	8.7	19.2
12	Saginaw (Saginaw)	71	42	8.4	3.3	3.3	6.3	28.7
13	Macomb (Mt. Clemens)	72	39	8.1	1.6	3.3	4.7	15.3
14	Marquette (Marquette)	74	33	7.2	3.6	2.8	5.6	30.2
15	Bay (Bay City)	59	30	7.3	1.1	6.1	9.8	26.7
	MICHIGAN TOTALS	68	38	7.8	2.3	4.2	7.0	20.9
	Specialty Categories:							
	GP and FP	68	2.9 (hrs)	8.9	5.3	1.3	2.0	14.4
	Internal Medicine	62	1.2	8.4	2.0	2.8	7.4	20.8
	General Surgery (GS)	81	1.0	6.1	1.4	2.2	2.8	18.4
	Michigan Average	69	1.8	8.0	3.1	2.1	4.2	17.8

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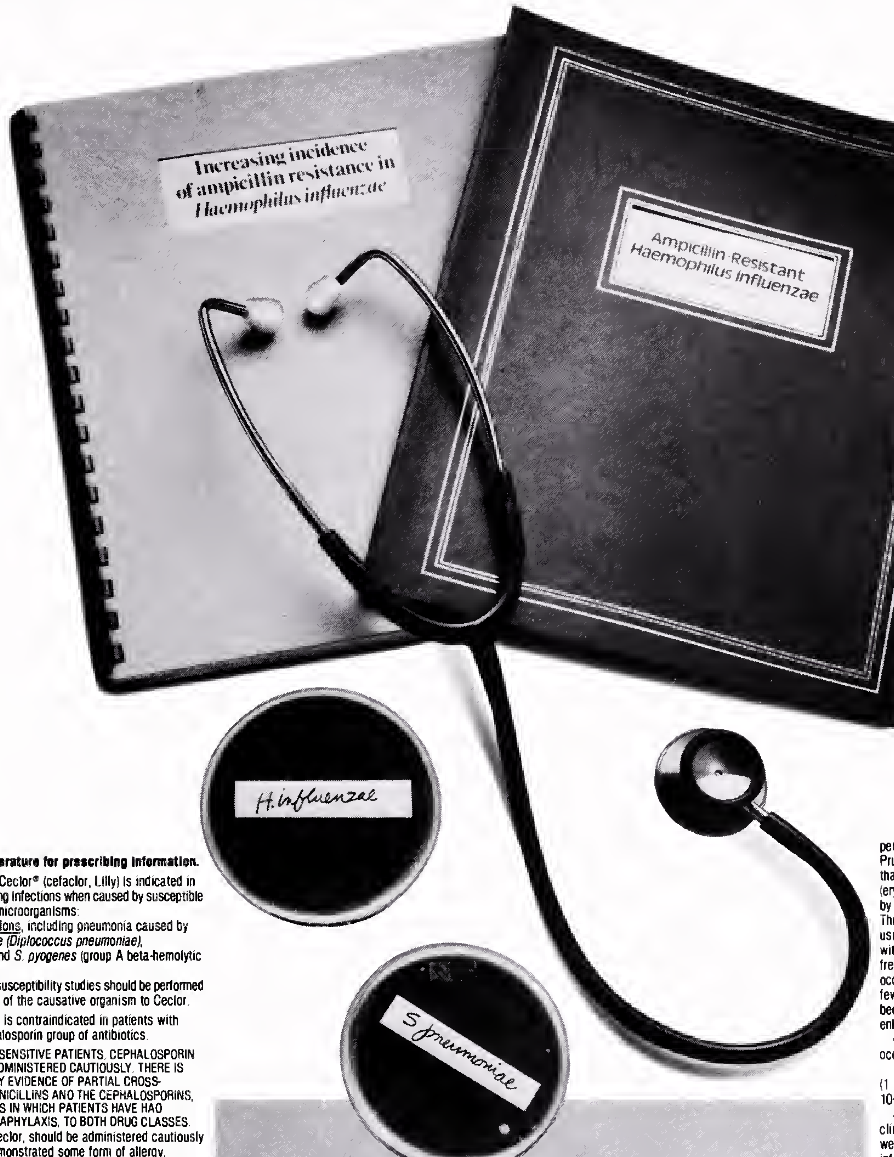
*Specialty values = Average weekend hours.

Table 4
PRACTICE CHARACTERISTICS (BY MARKET AREA AND SELECTED SPECIALTIES)

Market Area	Length of Office Visit	Office Room Wait	Wage Bill Per Visit
Oakland (Pontiac)	21 min.	17 min.	$3.17
Grand Traverse (Traverse City)	18	18	2.26
Ingham (Lansing)	19	15	3.87
Washtenaw (Ann Arbor)	23	11	3.16
Wayne (Detroit)	19	19	2.52
Muskegon (Muskegon)	20	21	2.74
Kalamazoo (Kalamazoo)	15	16	2.42
Genesee (Flint)	16	17	2.26
Emmett (Petoskey)	19	19	1.19
Berrien (St. Joseph)	15	17	1.03
Kent (Grand Rapids)	17	17	2.56
Saginaw (Saginaw)	16	19	2.08
Macomb (Mt. Clemens)	16	21	1.77
Marquette (Marquette)	18	18	2.42
Bay (Bay City)	16	21	1.88
MICHIGAN TOTAL	18	18	2.62
Specialty Categories:			
GP and FP	20	20	1.76
IM	27	19	2.98
GS	20	18	2.33

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S pneumoniae

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [100281R]

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Lilly

Additional information available to the profession on request from
Eli Lilly and Company,
Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

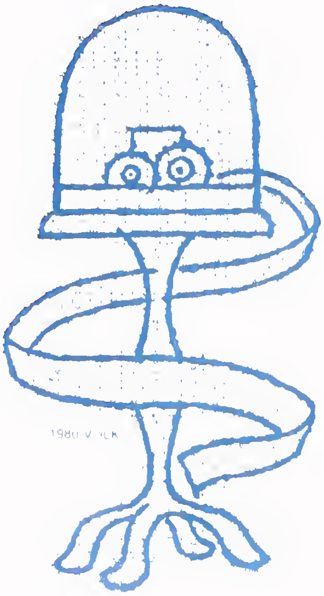
200066

FINANCIAL PLANNING/ INVESTMENT PERSPECTIVES

Why zero coupon bonds?

By Daniel L. Ludwin
East Lansing

Editor's note: With this article, *Michigan Medicine* continues a new series of articles to aid physicians in their personal financial planning. Author Daniel L. Ludwin welcomes MSMS members' questions on topics discussed in the articles. Mr. Ludwin will answer specific and unique questions directly, and will prepare further columns in response to questions which could be answered to the benefit of the general membership. Interested physicians may contact Mr. Ludwin by writing MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823.

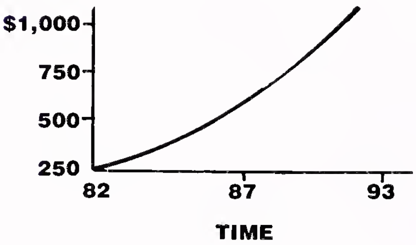


Mr. Ludwin is senior vice president of Prescott, Ball and Turben, investment bankers and brokers, East Lansing. He is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve funds assets. He has 15 years' experience in the financial field.

Most investors who have purchased bonds during the past 10 years are all too familiar with "discount bonds." They are bonds issued at par (100) and currently sell below that value. But few investors are familiar with "Original Issue Discount Bonds." These bonds are originally offered for sale to the investors at a price below their face value or par value. The amount of the original issue discount is treated by the bondholder as if it were interest.

What are they?

A zero coupon bond is a form of an original issue discount bond (OIDB). These bonds do not have a coupon, hence the zero, but merely a yield which is based upon a discounted dollar price for the bonds. The amount of the original issue discount must, therefore, be much greater than the more common discount bond because the bondholders' only return is the appreciation, or increase in value of the bond, from the purchase date to the date on which the bond matures. What this means is that if I pay $250 today for a bond that matures in 1993 at $1,000 the rate of interest imputed is approximately 13.5 percent compounded semi-annually. During that period however, I do not receive any interest payments (cash). The interest is, in essence, automatically re-invested. Theoretically, the bond should appreciate at 13.5 percent per year (see below).



Zero coupon bonds are issued by both corporations and municipalities, and therefore can be either taxable or non-taxable (tax-free).

The taxable "zero"

These bonds have been issued by such entities as the US Treasury, McDonalds Corporation and Allied Corporation.

Since they are issued by corporations, the IRS considers the "imputed" annual interest as taxable income. In other words, if I invest $1,000 in a zero coupon bond that matures in 1993 @ $4,000 the imputed interest rate is approximately 13.5 percent per year. The IRS would therefore consider that each year I will earn approximately $135 in interest and as such must pay tax on that $135 — even though I don't receive any cash. Because of this annual tax liability without corresponding cash flow until 1993, these bonds are not recommended for individual investors.

Where should they be used?

The ideal use for these bonds are in IRA — KEOGHS & Pension/Profit Sharing Accounts. The advantages are: (1) These bonds require a small minimum investment of $1,000. (2) They eliminate the problem of reinvesting income generated because it is in essence done automatically, and (3) Their price should be less volatile in the market place because they are already selling at a "deep" discount.

Tax-free zeros

This is a very exciting investment for investors in the higher tax brackets. As the IRS considers the return based on the original discounted price as interest and as interest on municipal bonds is federally tax-exempt, the entire difference between

Continued on page 579

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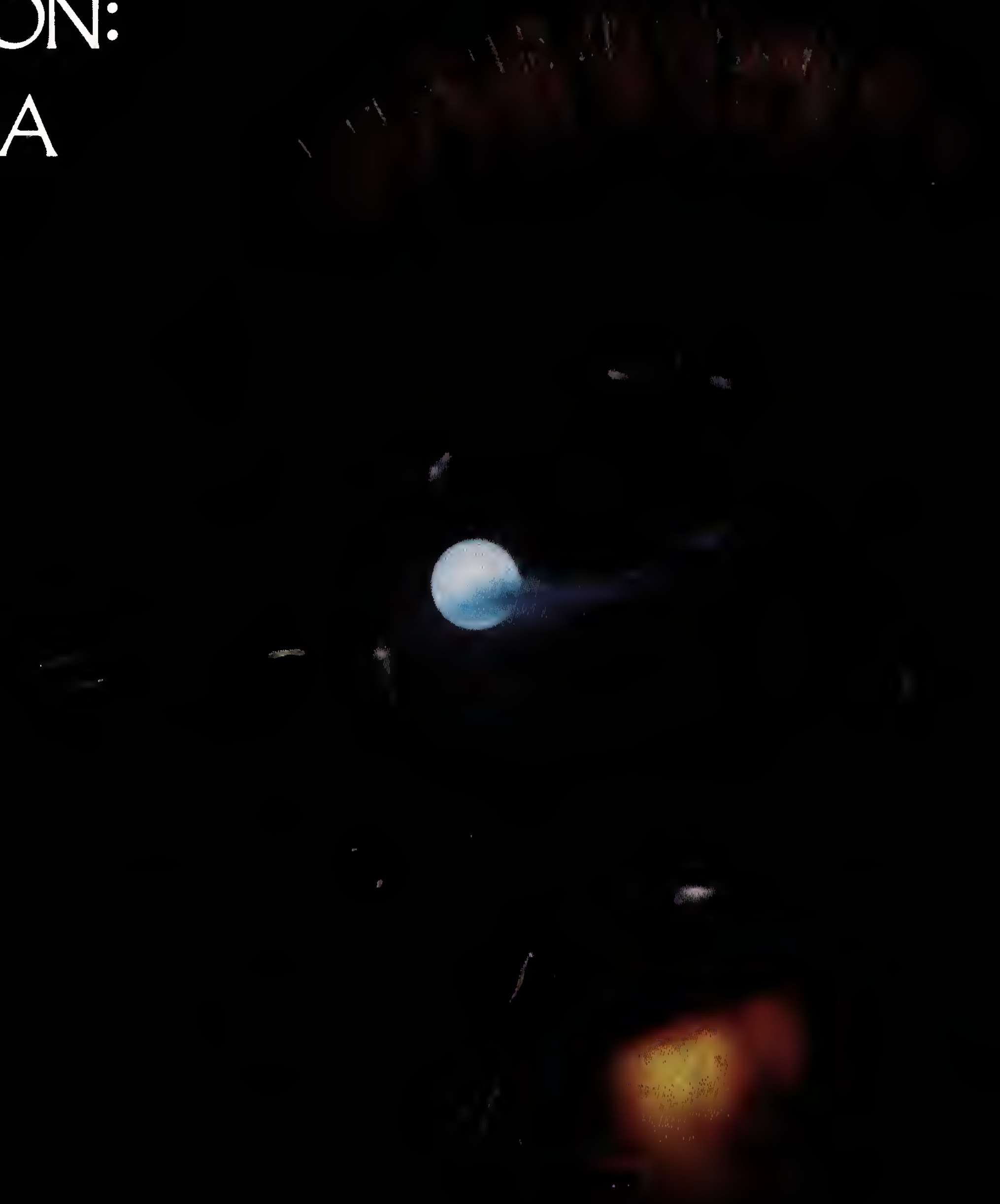
headache
vague aches
and pains
sadness
psychic and
somatic anxiety



Artist's conception,
looking out from the human eye
as conceived in a schematic model.

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LIMBITROL GIVEN H.S.: ONE OF THE VITAL SPECIFICS OF TREATMENT

Limbitrol brings a special—and specific—quality of relief to most anxious depressed patients. Insomnia, for example, responds with particular promptness. Other symptoms likely to respond within the first week of treatment include anorexia, agitation and psychic and somatic anxiety. And, as the depression and anxiety are alleviated, in many cases so are such related somatic symptoms as headache, palpitations, and various vague aches and pains.

Limbitrol given once daily h.s. may be the best approach

Many patients respond readily to a single bedtime dose of Limbitrol, a convenient schedule that may enhance compliance and helps relieve the insomnia associated with anxious depression. Limbitrol also offers a choice of other regimens: t.i.d., or a divided dose with the larger portion h.s. In all cases, caution patients about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as driving or operating machinery.

in moderate depression and anxiety

Limbitrol® Ⓒ IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Specific therapy with h.s. dosage convenience

Please see summary of complete product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required.
Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50.

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NEWSFRONTS

A new study at The University of Michigan Hospitals has demonstrated for the first time that increasing the heart's output, such as with a simple blood transfusion, relieves **paralysis due to stroke,** particularly cerebral vasospasm.

"Increasing general circulation promises to be a significant addition to treatment in the initial stages of stroke," said U-M neurosurgeon Ted S. Keller, MD. "By raising cardiac output in the laboratory, we successfully increased circulation to blood-starved areas of the brain. Applying these principles in stroke patients resulted in alleviation of paralysis in some cases, often within a few minutes, without endangering healthy brain tissue.

"Our laboratory study — along with actual clinical experience — shows this treatment to be safe, effective and relatively simple, since the heart automatically increases its output when blood or blood products are added to the body."

A low fat/high fiber diet in combination with specific vitamin supplements may be the best way to prevent cancer of the colon, or large intestine.

Norman Nigro, MD, professor of surgery at Wayne State University School of Medicine reported these findings in the July issue of the *Journal of the National Cancer Institute* after several years of studies on laboratory rats (who possess a remarkably human-like intestinal system).

Doctor Nigro suggests that few would adhere to the drastic changes in their daily diets needed to reduce the chances of cancer. Therefore, he is attempting to prevent colon cancer by adding specific supplements, shown to inhibit cancer growth, to a program of modest dietary change.

The studies revealed that the combination of three micro-nutrients — selenium, retenoids and plant steroids (beta-sitosterol) — plus fiber given daily did inhibit the formation and growth of tumors in the colon of laboratory animals by more than 50 percent.

Deaths following legal abortion have fallen sharply since 1975 in contrast to maternal deaths during the nine months of pregnancy, which have declined at a slower pace, according to an analysis by the Centers for Disease Control (CDC) in the *Journal of the American Medical Association.*

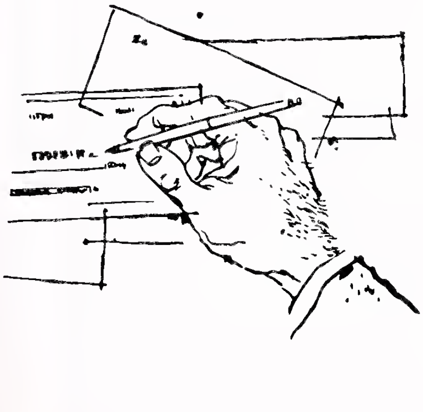
The authors conclude that the risk of a healthy woman's dying from elective abortion is extremely rare. Women with chronic heart disease or other serious preexisting conditions, though, have a greatly increased risk regardless of whether they seek abortion or choose to carry the baby through to delivery. Even so, abor-

Continued on page 582

BONDS/*Continued*

the original discounted purchase price and the face (or par) value of the bond is tax-free. An example of this is a recently issued AAA rated insured municipal zero coupon bond, discounted to yield 12 percent. An investment of $70,000 in that issue would produce $1,043,000 in just 23 years. That's right — a million dollars in 23 years — tax free.

The minimum investment in these bonds is generally $5,000 and along with their taxable counterparts, they can be sold during their holding period. The price, of course, would be dictated by interest conditions at the time of sale.



Word of caution

When purchasing any bond, especially zero copon bonds, the investor must be sure of the credit worthiness of the issuer. As indicated in the above example many issues fortunately are insured by MBIA and carry a AAA rating.

What's news

In last month's article I mentioned that some changes had been proposed for Single Premium Deferred Annuities. A summary of those congressional changes are listed below.

1. Five percent penalty for early withdrawal.
2. Early withdrawal is defined as any withdrawal before age 59½ or before a 10-year holding period.
3. Accounting method changed from FIFO to LIFO.
4. Retirement plans basically unaffected.

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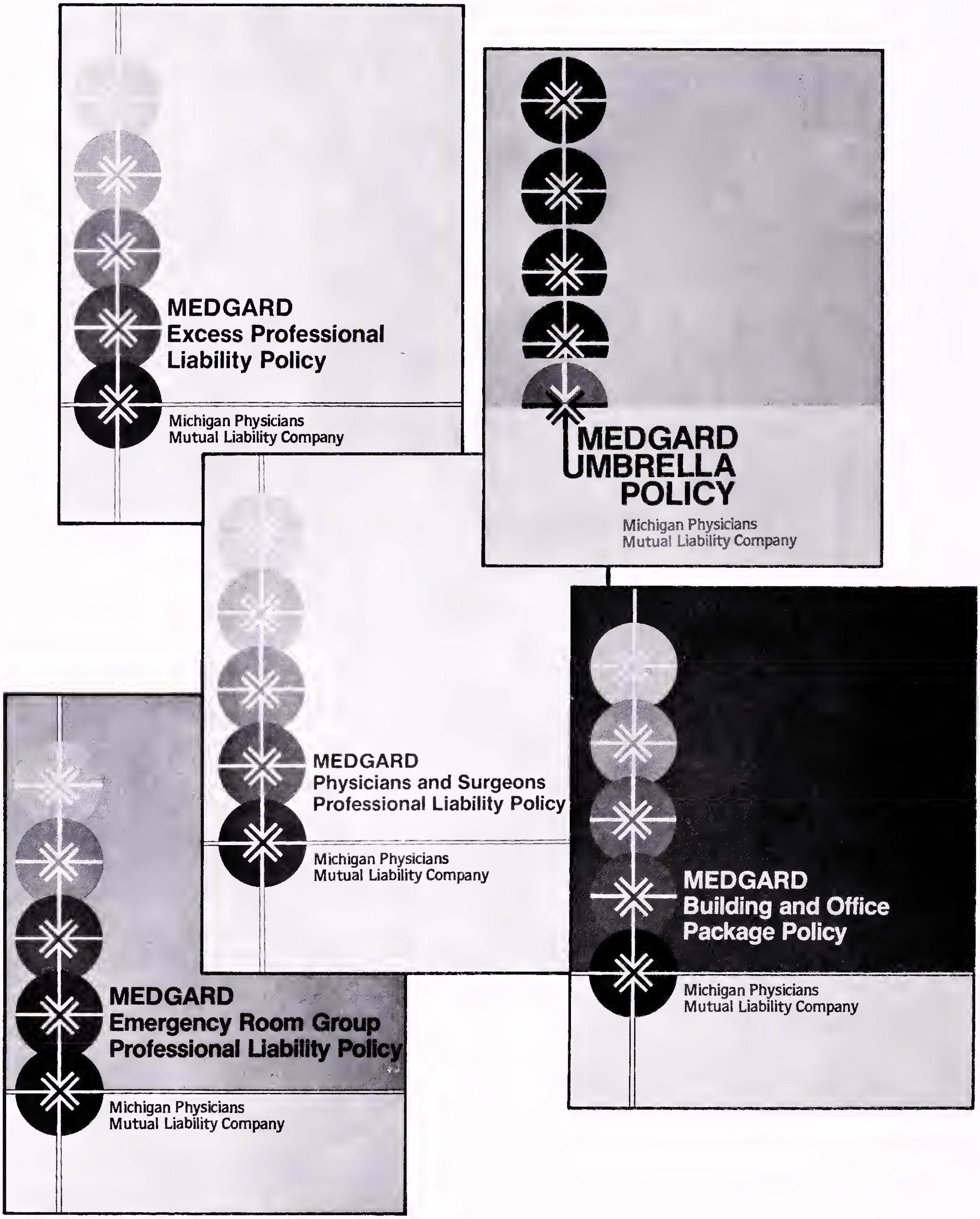

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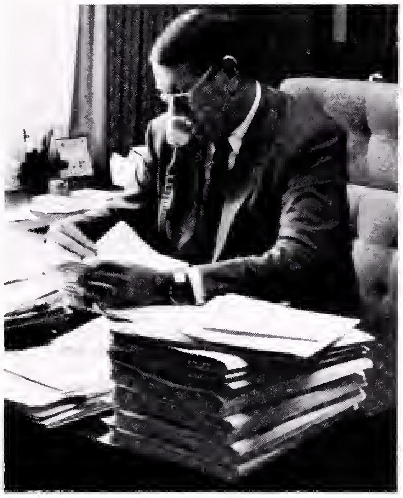
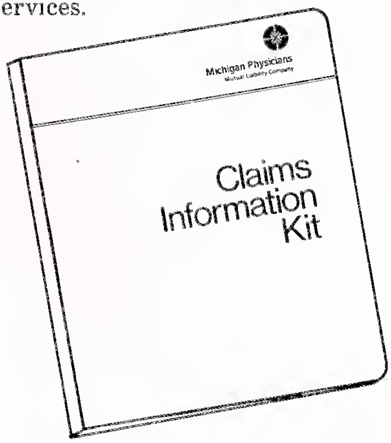


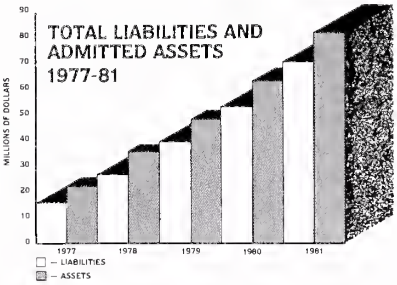
Service. Claims service is what you buy a professional liability policy for in the first place. Our policies are backed by the most experienced professional liability claims staff in Michigan. Our claims representatives return your phone calls and keep you informed of the progress of any claim in which you may be involved. These professionals and the excellent defense attorneys assigned to represent our policyholders have helped Michigan Physicians build our excellent reputation for claims services.



Communication. Our Closed Claim Questionnaire and the newly revised Claims Information Kit are examples of how we communicate with the physicians we insure. The MUTUAL MONITOR (our quarterly newsletter), risk management seminars, and special meetings at hospitals are other examples of how we are bringing information to the medical profession on a continuing basis.

Innovation. Our in-house computer system has streamlined company operations and enabled our staff to answer your questions about underwriting or claims immediately. This system is one of the most sophisticated in the nation and our data base of claims statistics pinpoints actuarial projections and provides research information for risk management programs.

Stability. Assets of over $88 million back our policies. That's more than $20,000 for each physician insured with us for primary, professional liability. Total surplus of $11.4 million is further evidence of our financial strength and stability. In other words, our policyholders have $3 of equity for every $4 of net premium that we write annually.



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If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

tion is probably the safest option for these women, in terms of mortality risks, the authors say.

Statistics from the Centers for Disease Control, Atlanta, show convincingly for the first time that **barrier contraceptives** protect against a disease that strikes women almost a million times a year.

Joseph Kelaghan, MD, the principal analyst, and a team of CDC medical epidemiologists reported in the *Journal of the American Medical Association* that women who use barrier contraceptives are 70 percent less likely to develop pelvic inflammatory disease (PID) requiring hospitalization than women who use intrauterine devices.

Barrier method users are about as protected from developing PID requiring hospitalization as women who use oral contraceptives, which have been shown in at least two other studies to confer protection from PID.

The CDC data were derived from 645 women patients and 2,509 control subjects aged 18 to 44 years identified in the National Institutes of Health-CDC's Women's Health Study, a multihospital study of the relationship between contraceptive methods and hospitalization for gynecologic disorders. Barrier methods mentioned by women in the study included condoms, diaphragms and spermicidal foams, jellies and creams, used alone or in combination.

The health care needs of homosexuals can be better served by increasing both physician and patient awareness and by enhancing their cooperation, according to a report by the American Medical Association Council on Scientific Affairs.

The report calls for strengthening AMA efforts to educate physicians regarding the special needs of homosexuals and for programs to educate homosexual patients regarding the diseases for which they are at risk. The report emphasizes the vital role a comprehensive medical history, including the patient's sexual orientation, can play in effective treatment.

Based in part on material from the AMA book *Sexual Problems in Medical Practice*, the report describes the special health care needs of homosexuals, who constitute an estimated five to 10 percent of the population.

Much of the current literature dealing with medical treatment of homosexuals focuses on sexually transmitted diseases in men. These include syphilis, gonorrhea, venereal herpes, hepatitis B and infections caused by protozoa.

Also, opportunistic infections and other disorders, such as Kaposi's sarcoma, may be associated with a state of impaired immune response in some homosexual patients.

Computer technology is making it easier and safer to obtain x-ray images of **arteries clogged by arteriosclerosis,** according to a team of California radiologists.

By combining electronic x-ray detection methods and digital computer techniques (similar to those used in CAT scanning) radiologists can cancel out x-ray shadows made by bones and soft tissue to obtain clear images of underlying arteries.

Writing in the *Journal of the American Medical Association*, William R. Brody, MD, associate professor of radiology, Stanford University School of Medicine, and colleagues say that digital subtraction angiography is useful for evaluating major vessels such as the aorta, the carotid arteries supplying blood to the brain, the iliac and femoral arteries serving the legs, and the renal arteries nourishing the kidneys.

The technique will have to be improved, however, before it can be used to study the coronary arteries and intracranial vessels, according to Doctor Brody.

People with **borderline hypertension,** for whom treatment is still controversial, can effectively reduce their blood pressure by taking a single drug in doses small enough that side effects are minimal, a Michigan study has found.

According to physicians at the University of Michigan School of Medicine who conducted the study, home blood pressure monitoring was found to be a sensitive gauge of the adequacy of treatment.

A problem in assessing the ef-

Continued on page 584

FINANCIAL INFORMATION

NAME________________HOME PHONE____________OFFICE PHONE____________

	DESCRIPTION	SELF	JOINT	SPOUSE
REAL ESTATE	RESIDENCE	$	$	$
	OTHER			
LIFE INS.	GROUP			
	PERSONAL			
EMPLOYEE BENEFITS	PENSION			
	PROFIT SHARING			
	OTHER			
STOCKS	MARKETABLE			
	CLOSELY HELD			
	BANK ACCOUNTS			
	BONDS			
	PARTNERSHIPS			
	PROPRIETORSHIPS			
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fects of treatment on those with borderline hypertension has been the variability of blood pressure readings. It has been known for some time that blood pressures taken in a clinic or office setting tend to differ from measurements taken at home.

Writing in the *Journal of the American Medical Association*, Christopher Cottier, MD, and colleagues report that a group of borderline hypertensive patients taking antihypertensive drugs or placebos who measured their blood pressure at home were able to detect accurately very small changes in pressure.

Their readings were more reflective of their true blood pressure status than readings obtained in a physician's office would be, the author suggests.

Doctor Cottier's team studied 16 subjects, 15 men and one woman, ranging in age from 24 to 47 years. They were divided into two groups, one receiving propranolol hydrochloride and the other receiving clonidine hydrochloride for a period of three weeks.

During a second three-week period both groups received a placebo, and during a final three-week period each group received the active drug not previously used for that group. Both drugs produced only small decreases in blood pressure, but in patients with borderline hypertension, drops of only 5 to 10 millimeters of mercury are sufficient to achieve normal levels, the authors point out.

Propranolol and clonidine belong to the antiadrenergic group of drugs, which reduce blood pressure by inhibiting factors that tend to constrict blood vessels. The drugs, which are usually prescribed in combination with diuretics, were given alone and in minimum recommended dosages for the purposes of this study.

The results show that, used in this way, propranolol or clonidine can lower blood pressure to normal in borderline hypertensive patients and that the patients can effectively monitor their response to the drugs at home.

The Michigan team recommends home blood pressure monitoring to avoid the generally higher and more variable readings obtained in a physician's office, explained Stevo Julius, MD, head of the university's Division of Hypertension, in a separate interview.

Blood pressure readings in the office setting are usually affected by emotional factors, such as general apprehension. Home blood pressure monitoring has been found to be influenced less by external factors, Julius said.

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The Veterans Administration has established a **Physician Placement Service** in Randolph, MA, that enables VA Medical Centers throughout the United States to identify physicians who meet the specialty needs of the various medical centers. The placement service allows interested physicians to apply for openings throughout the entire VA system by submitting a single application to the Physician Placement Service.

Qualifications and practice preferences are computer "matched" with VA Medical Center requirements. A list of interested, qualified applicants for each available position is generated within 24 hours of receipt of a request from a VA Medical Center. The applications and references of each "matched" applicant are then forwarded to the requesting Medical Center. The Medical Center then arranges interviews, and evaluation and hiring decisions are made.

The VA operates the nation's largest medical care delivery system with over 170 health facilities nationwide. Most VA Medical Centers maintain active affiliations with nearby medical schools and offer physicians a choice of clinical, teaching, and/or research opportunities.

For further information and application, write to: VA Physician Placement Service, P.O. Box 719, Randolph, MA 02368, or call 1-800-343-8831 outside Massachusetts (toll free).

DEFLATION

Something physicians won't see this year. Except members of the Michigan State Medical Society. For them, group term life insurance premiums have been deflated. On March 1st, premiums for most physician members were reduced up to:

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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J-9043-4 July 1981

In the treatment of insomnia

Good mornings start with restful nights.

Dalmane *(flurazepam HCl/Roche)* patients fall asleep faster, sleep longer and seldom awaken with morning hangover.

Feeling well rested in the morning usually means having slept well the night before. And for insomniac patients receiving hypnotic therapy, a good morning also means awakening with few side effects from their medication. Many physicians choose Dalmane for their patients who suffer from insomnia for this very reason.

Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.[1] In a double-blind crossover study of 42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.[2] This difference was highly significant ($p<0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.[3]

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.[4] The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.[5-8] Since the risk of oversedation, dizziness, confu-

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Contemporary Hypnotic Therapy '82

sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.[1] Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.[9,10] However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.[11] When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

References: **1.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **3.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **4.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Meyer JA, Kurland KZ: *Milit Med 138*:471-474, Aug 1973. **6.** Feffer HL, Gibbons B: *Med Times 101* (8):130-135, Aug 1973. **7.** Jacobson A *et al*: *Psychophysiology 7*:345, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 1978. **10.** Kales A *et al*: *JAMA 241*:1692-1695, Apr 1979. **11.** Monti JM: *Methods Find Exp Clin Pharmacol 3*(5):303-326, 1981.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Letter on evaluation of disability draws comment

The letter from Herman Meltzer, MD (*AMN*, May 28, 1982) makes some valid points, but there is one aspect of his remarks that warrants comment. It is not sufficient for a patient to have his (disability) evaluation determined solely by the examining physician, because the patient's physician will sometimes go along with a patient's request for disability.

Since physicians are human, they don't want to antagonize their patients and accede to requests to certify disability, without objective findings. We don't want hostile patients, so we accede to their demands.

It is suggested that Dr. Meltzer peruse *Disability Evaluation under Social Security, a Handbook for Physicians*, especially the bottom paragraphs on pages 1 and 13. Also, it is pointed out (on page 3): ". . . the decision as to whether the impairment constitutes a disability is an administrative, not a medical decision." We would agree, of course, that the decision is made on medical evaluation and evidence.

WALTER A. SCHLOSS, MD
West Hartford, Conn.

The letter to the editor at left appeared in the July 9, 1982 edition of *American Medican News*. A free copy of the *Handbook for Physicians* can be obtained by writing to:

Harry D. Nesmith, MD
Chief Medical Consultant
Disability Determination Service
Box 30011
Lansing, 48909

World Medical Relief

What a great honor to appear on the cover of the *Michigan Medicine* magazine and to be highlighted in your special report on humanitarian service.

The pictures and story of World Medical Relief are very well done and I hope you will extend my gratitude to the photographer also. If the two responses we have already received are any indication of any future responses to this article and your plea for help, our prayers will have been answered.

We already have received two responses from your article — a retired doctor from Kalamazoo sent us a check for $50 and a group of physicians were interested in methods of getting their drug samples to us. I hope this is an indication of the type of response the article will bring forth as we can certainly use both types of assistance.

We were wishfully thinking that if every physician that read the article followed the Kalamazoo doctor's concern and mailed us a $50 check, our present financial problems with having to buy 15 percent of drugs for our tri-county program would be solved. From January to June 1982, we filled 11,000 perscriptions valued at $156,190.19 for this program alone.

I'm going to make some contacts with regard to having the front cover and the article reprinted and sending these to the pharmaceutical companies who have not responded favorably to our requests for assistance. I would think that if nothing else can move their hearts, this article in the magazine which the Michigan State Medical Society sponsors, will do the trick.

Mrs. L. G. Auberlin
President, World Medical Relief
Detroit

Michigan Board of Medicine DISCIPLINARY ACTIONS

- **James McCourt, MD**

926 N. Michigan Avenue
P.O. Box 3216
Saginaw, 48605

Date, action taken

6/29/82
Reprimand & Probation effective 6/29-82 to 6/29/83

Violation

16221(a)
16221(b)(i)
16221(c)(iv)

- **William E. Taylor, II, MD**

2701 Washtenaw Avenue
Ann Arbor, 48104

Date, action taken

4/14/82
Reprimand & Probation
4/14/82 to 4/15/85

Violation

16221(b)(ii)
16221(b)(iii)

- **Paul E. Larkey, MD**

11653 S. Hartel Road
Grand Ledge, 48837

Date, action taken

6/9/82
Reprimand & Probation effective 6/9/82 to 6/9/83

Violation

16221(c)(iv)
16221(b)(i)
16221(a)

- **Edward W. Walters, MD**

7457 Gratiot
Detroit, 48213

Date, action taken

8/6/82
Revoked effective
8/6/82

Violation

16221(b) (iii)

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Bethesda Hospital and Deaconess Association
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Cincinnati, OH 45206
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5.5 Category I Credits awarded for attendance

NEWS

By Sheri W. Greenhoe
East Lansing

Doctor Breneman

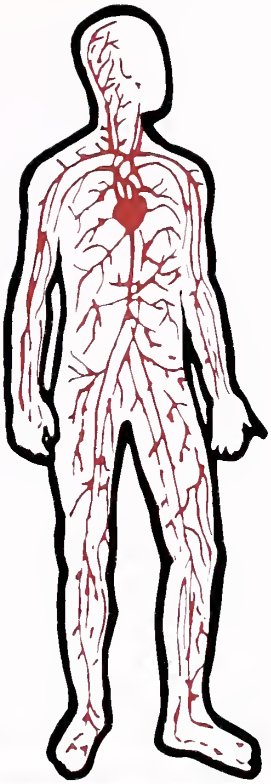
Doctor Cantrell

Doctor Davis

Doctor O'Connor

Gerald Davis, MD, Escanaba, has been appointed by Governor Milliken to the Michigan Aeronautics Commission for the remainder of a term expiring next May. Doctor Davis is a medical examiner for the Federal Aviation Association and is a member of the Civil Aviation Medical Association and the Aeronautics Space Medical Association . . . The "most outstanding house officer in the department of internal medicine" at the U-M Hospitals is **Eleanor Davidson, MD.** The award recognizes the house staff member who is "outstanding in providing devoted care and teaching to patients, medical students, nurses and fellow physicians . . ." . . . **David M. Luoma, MD,** and **Eric J. Ittner, MD,** both of Marquette, have been appointed directors of the Marquette Family Practice Residency Program, according to the Upper Peninsula Health Education Corporation. . . . Newly elected officers of the Michigan Radiological Society are: **David P. Corbett, MD,** Detroit, president and **Francis P. Shea, MD,** Grosse Pointe, president-elect. . . . First woman chairman of a medical department at Henry Ford Hospital is **Mary E. Cantrell, MD,** Bloomfield Township. Doctor Cantrell heads the Department of Anesthesiology. . . . **Otelio S. Randall, MD,** U-M associate professor, has received the H. Marvin Pollard Award for outstanding teaching from the senior medical residents completing house staff training in internal medicine. . . . New president of the American Orthopaedic Society for Sports Medicine is **Gerald A. O'Connor, MD,** U-M team physician and orthopedic surgeon. Doctor O'Connor also is director of the sports medicine clinic at U-M Hospitals, and head of orthopedic surgery at St. Joseph Mercy Hospital. . . . New Michigan Academy of Family Physicians officers include: **Harold F. Kendrick, MD,** Pontiac, president, Medical Director for General Motors; **William W. Allen, MD,** Hastings, president-elect, family physician; and **Robert J. Toteff, MD,** Detroit, vice-president, director of the WSU/Harper-Grace Hospitals Family Practice Residency Program. . . . Recipient of the Jerome W. Conn Award for distinguished research by a junior faculty member of the department of internal medicine in the U-M Medical School is **Stephen J. Weiss, MD.** Doctor Weiss' research interests center on the role of oxygen products as mediators of tissue damage. . . . **William N. Kelley, MD,** chairman of internal medicine at the U-M Medical School, has been elected president of the American Society of Clinical Investigation. He will assume office in May of next year. . . . **J.C. Breneman, MD,** Gobles, was chairman of the International Food Allergy Symposium held in Vancouver, B.C. in July. The meeting was an assembly of the outstanding international scientists in the field of immunology of food intolerance. . . . **B. Ken Gray, MD,** Bloomfield Hills, was honored recently by a resolution of the Michigan Legislature, recognizing him as president of the American College of Emergency Physicians. . . . **Halley Faust, MD,** and **William E. Thar, MD,** co-owners of Health Analysts, Inc., and the Preventive Medicine Center of Ann Arbor received the Governor's Physician Fitness and Health Award for 1982. The annual award recognizes contributions in health and fitness as part of the overall health promotion and disease prevention efforts in Michigan. . . . Michigan Academy of Family Physicians "Family Physician of the Year" is **Doris Dahlstrom, MD,** Kalamazoo. Doctor Dahlstrom was chosen for the academy's top award because of her "professional attainment, community involvement and humanitarian achievement." . . . New chairman of the department of postgraduate medicine and health professions education at the U-M Medical School is **Roland G. Hiss, MD.** He had been serving as the department's acting chairman since January, 1981. . . . **Donald Smith, MD,** Sisters of Mercy Health Corporation, Farmington Hills, was recently appointed to the Michigan Hospital Association's Committee on Legislation. . . . The National Institute of Allergy and Infectious Diseases has awarded a five-year $770,000 grant to **Albert F. LoBuglio, MD,** director of the U-M Simpson Memorial Research Institute, for a study of certain blood diseases. His project will seek to characterize the antibodies on red blood cells or blood platelets of patients with anemia or thrombocytopenia. . . . **John F. Fennessey, MD,** Grosse Pointe pathologist, **Hermann A. Ziel, Jr., MD,** East Lansing, and **William Anderson, DO,** Southfield surgeon, were appointed to the Hospital Capacity Reduction Corporation and its Board of Trustees by Governor Milliken. The private nonprofit corporation was established to facilitate the process of hospital consolidation. . . . "Teacher of the Year" at Harper-Grace Hospitals is **Keith A. Brady, MD,** Detroit, selected by the medical residents there. . . . **Douglass Haddock, MD,** Kalamazoo, is the Michigan Academy of Family Physicians' candidate for AAFP vice president. He currently is chairman of the AAFP Board of Directors, and is past president of the Michigan Chapter.

Ms. Greenhoe is editorial secretary to *Michigan Medicine.*



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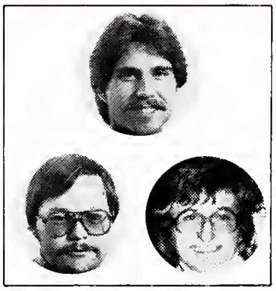

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MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

Oct. 27 — MSMS Component society executives' session, Lansing, contact: Wayne Burmeister, MSMS headquarters.

Oct. 28 — MSMS Leadership/Public Affairs Conference, Long's Convention Center, Lansing, contact: Bill Madigan or Kevin Kelly at MSMS headquarters.

Nov. 6-7 — Medical Assistants Fall Leadership Training Seminar, "Chase the Rainbow," Kalamazoo Center, Hilton Hotel, contact: Margaret Gray, CMA-C, 23548 Lauren Lane, Warren 48089 (313) 777-2827 or (313) 573-4820 (afternoons).

Nov. 8 — MSMS/A State Board Meeting, MSMS headquarters, contact: Caroline Rich, 517/337-1351.

Nov. 9-10-11 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Nov. 17 — MSMS Program to Assist Impaired Physicians, "Training of Trainers," MSMS Headquarters, East Lansing, contact: Katie Brewbaker 517-337-1351.

Jan. 28-30, 1983 — Medical Assistants Midwinter Seminar, "Up, Up and Away with AAMA," Eastpointe Chapter, Michigan Inn, Southfield, contact: Margaret Gray, CMA-C, 23548 Lauren Lane, Warren 48089 (313) 777-2827 or (313) 573-4820 (afternoons).

Feb. 4-19, 1983 — MSMS/INTRAV South African Adventure, contact: Donna Farougi, MSMS headquarters, 517/337-1351.

Feb. 12-19, 1983 — MSMS/INTRAV West Indies Air/Sea Cruise, contact: Donna Farougi, MSMS headquarters, 517/337-1351.

Feb. 19-March 7, 1983 — MSMS/INTRAV Australian Adventure, contact Donna Farougi, MSMS headquarters, 517/337-1351.

March 6, 1983 — Medical Assistants State Board Meeting, MSMS headquarters, East Lansing, contact Margaret Gray, CMA-C, 23548 Lauren Lane, Warren 48089 (313) 777-2827 or (313) 573-4820 (afternoons).

April 21-24, 1983 — Medical Assistants State Annual Convention, "Aloha," Plymouth Hilton, Macomb Chapter, contact Margaret Gray, CMA-C, 23548 Lauren Lane, Warren 48089 (313) 777-2827 or (313) 573-4820 (afternoons).

Other meetings

Sept. 17-19 — "EMS in Our Lives" conference, Michigan Association of Emergency Medical Technicians, Hyatt Regency, Dearborn, contact: MAEMT Convention Registrar, PO Box 118, Union Lake, MI 48085.

Sept. 29-Oct. 1 — Michigan Society for Respiratory Therapy Annual Northern Michigan Michigan Clinical Seminar, Grand Hotel, Mackinac Island, contact: Lee Ras, RRT, c/o Respiratory Therapy, Northern Michigan Hospitals, Petoskey 49770.

Oct. 2 — Michigan Chapter of American Medical Writers Association medical writing workshop, "From the Rat to the Reader," Holiday Inn, Kalamazoo, contact: Jan Carnes, Upjohn Company (616) 323-6153, or Doctor Cornett, Henry Ford Hospital (313) 876-2028.

Nov. 10 — Michigan Society of General Surgeons Annual Membership Meeting, Hyatt Regency Dearborn, contact Caroline Rich, MSMS headquarters, (517) 337-1351.

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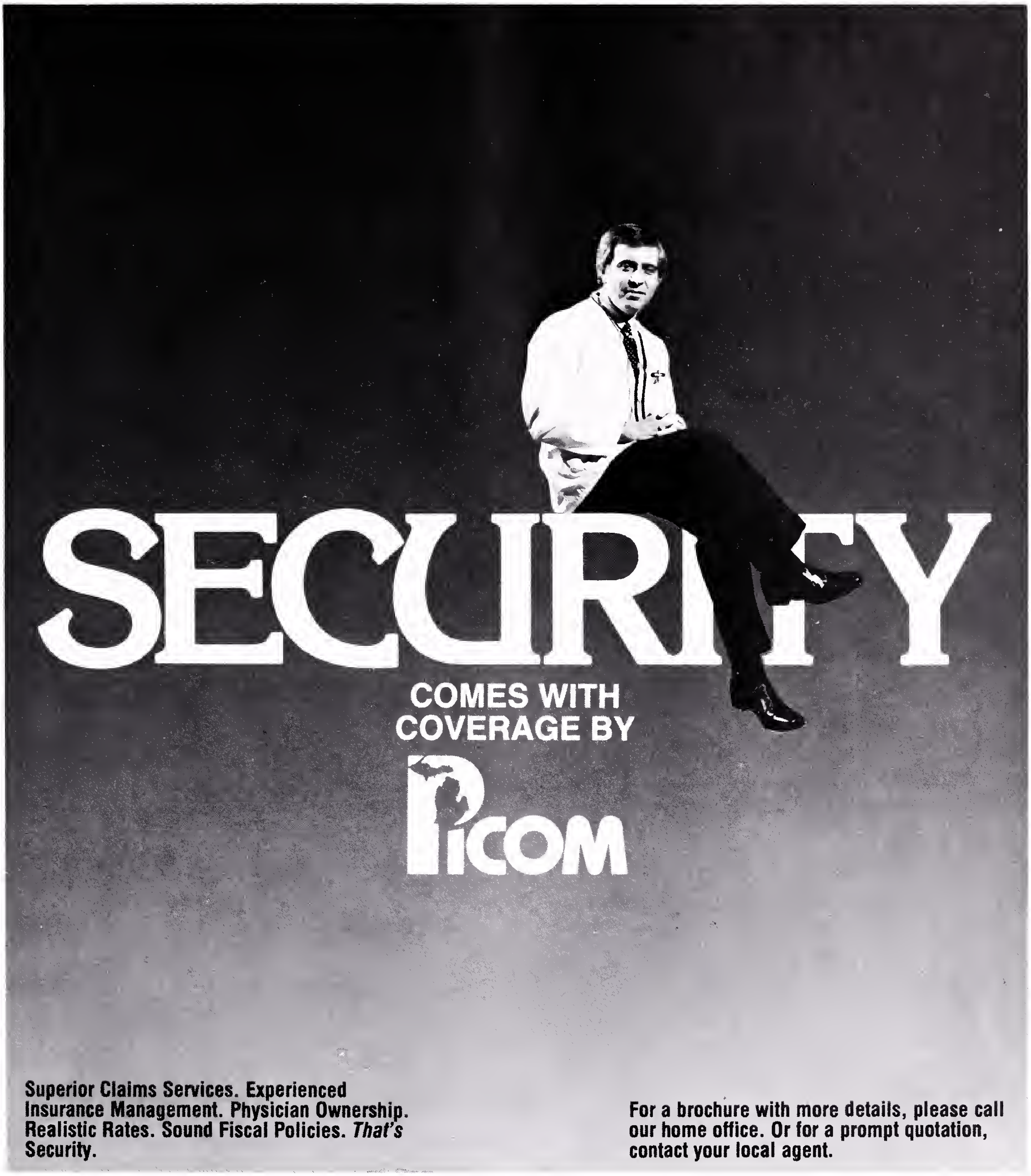

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CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Oct. 25-29, Craniosacral Technique. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: October 29-30, Injectable Collagen: Investigation, Application, and Techniques. Location: Towsley Center for CME, U-M, Ann Arbor. **Sponsor:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, U-M Medical Center and The Department of Dermatology. **For:** Dermatologists, dermatological surgeons, head and neck surgeons, and others interested in reconstructive surgery of the skin. **Cost:** $155. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: Nov. 1-5, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Kellogg Center, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Nov. 2-4, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: Nov. 3, 22nd Annual Thyroid Workshop. Location: Gordon H. Scott Hall of Basic Medical Sciences, WSU School of Medicine, Detroit. **Sponsor:** WSU School of Medicine, Dept. of Internal Medicine, Division of Endocrinology. **For:** Endocrinologists, family physicians, general surgeons and internists. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 6 hours of Category I Credit.

Nov. 5-6, Nutritional Support of the Hospitalized Patient. Location: Towsley Center for CME, U-M Medical Center, Ann Arbor. **Sponsor:** Dept. of Postgraduate Medicine and Health Professions Education, U-M. **Cost:** $155 for physicians; $115 for Physicians-in-Training and Retired physicians; $115 for allied health professionals. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 9 hours of Category I Credit.

Date: Nov. 8-10. Manual Medicine to the Extremities. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Nov. 9-11. MSMS Annual Scientific Meeting. Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** Sherry Fent, MSMS headquarters (517) 337-1351. **Approved for:** Up to 18 hours of Category I Credit.

Nov. 11-13, Clinical Oncology. Location: Towsley Center for CME, U-M Medical Center. **Sponsor:** Dept. of Postgraduate Medicine and Health Professions Education. **Contact:** Con-

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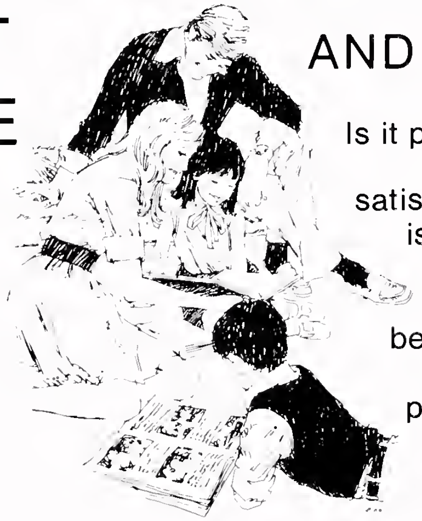

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tinuing Medical Education, Towsley Center, Box 057, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 17 hours of Category I Credit.

Nov. 12-13, Thirtieth Annual Symposium on Trauma. Location: Harper Hospital, Kresge Auditorium, 3990 John R, Detroit. **Sponsor:** Michigan Committee on Trauma of the American College of Surgeons, the Michigan Chapter of the American College of Emergency Physicians, and the Department of Surgery, WSU. **Contact:** WSU Department of Surgery, (313) 577-5009. **Approved for:** 9 hours of Category I Credit.

Date: Nov. 18-19-20, Acute Injuries of the Hand: Primary and Definitive Care. Location: Westin Hotel, Detroit. **Sponsor:** WSU School of Medicine Department of Surgery. **Contact:** WSU School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 19 hours of Category I Credit.

Nov. 19-20, Soft Tissue Expansion in Reconstructive Surgery. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education. **Cost:** $350-practicing physicians; $225-physicians-in-training. **Contact:** Office of CME, Dept. of Postgraduate Medicine & Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 12 hours of Category I Credit.

Nov. 19-20, Common Surgical Problems in Childhood. Location: Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** U-M Medical School Office of CME, Dept. of Postgraduate Medicine & Health Professions Education and The Surgical Services of Mott Children's Hospital. **Cost:** $155-physicians; $125 physicians-in-training; $125 allied health professionals. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: Nov. 20, Surrogate Mother Symposium. Location: McGregor Memorial Conference Center, Wayne State University, Detroit. **Sponsor:** WSU Schools of Medicine and Law. **For:** OB/GYNs and others interested in fertility issues. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 26-30, Ophthalmology: Basic and Clinical Review. Location: Hyatt Regency Dearborn. **Sponsor:** Kresge Eye Institute, WSU School of Medicine. **For:** Practicing and resident ophthalmologists. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 44 hours of Category I Credit.

Dec. 3, Care of the Burned Patient. Location: Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** Office of CME, Dept. of Postgraduate Medicine & Health Professions Education, the National Institute for Burn Medicine, and The University of Michigan Burn Center. **Cost:** $115 physicians; $85 physicians-in-training and retired physicians; $85 allied health professionals. **Contact:** Office

Continued on page 598

Tortola, British Virgin Islands **February 2-6, 1983**

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CATEGORY I/*Continued*

of CME, Towsley Center, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 7 hours of Category I Credit.

Date: Dec. 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Dec. 27-31, Clinical Medicine Update II: An Educational Retreat. Location: San Diego. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education. **For:** Clinicians in internal medicine, family practice, general practice, general surgery, pediatrics, and obstetrics and gynecology. **Cost:** $325. **Contact:** Office of CME, Towsley Center for CME, U-M Medical School, Box 057, Ann Arbor 48109 (313) 763-1400. **Approved for:** 18 hours of Category I Credit.

Jan. 22-29, Aspen Conference on Emergencies in Medicine. Location: Aspen Conference Center, Aspen, Colorado. **Sponsor:** WSU Department of Surgery. **Contact:** Theresa Sokol, Department of Surgery, WSU, 6-C University Health Center, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 27.5 hours of Category I Credit.

Date: Feb. 13-19, 1983, Myocardial Infarction and Angina Pectoris. Location: Davos, Switzerland. **Sponsor:** Division of Cardiology of the Hannover Medical School, Hannover, West Germany, and the University of Michigan. **For:** All physicians and surgeons with an interest in ischemic heart disease. **Cost:** $300. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center for CME, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 28 hours of Category I Credit.

Date: Feb. 23-March 1, 1983, Adolescent/Young Adult Medicine. Location: Wailea Beach Hotel, Maui, Hawaii. **Sponsor:** Hurley Medical Center, Department of CME. **Contact:** Hurley Medical Center, Dept. of CME, One Hurley Plaza, Flint 48502, (313) 766-0142. **Approved for:** 20 hours of Category I Credit.

Date: April 8-10, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: June 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Medicine, MSU, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine, Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 21-23, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

Organizations:

Academy of Plastic Surgeons, Grosse Pointe Woods
American Academy of Clinical Toxicology, Detroit
American Academy of Pediatrics-Michigan, Grand Rapids
American Lung Association-Michigan/Southeast Michigan, Lansing
American Physiological Society, Ann Arbor
American Society of Colon and Rectal Surgeons, Detroit
American Society of Dermatopathology, Ann Arbor
Ann Arbor Psychiatric Association, Ann Arbor
Bay County Medical Education, Bay City
Lakeshore Continuing Medical Education, Inc., Muskegon
Michigan Academy of Family Physicians, Lansing
Michigan Department of Mental Health, Office of Resource Development, Lansing
Michigan Dermatological Society, Southfield
Michigan Heart Association, Southfield
Michigan Ophthalmological Society, Harper Woods
Michigan Psychoanalytic Institute, Southfield
Michigan Psychoanalytic Society, Southfield
Michigan Society of Anesthesiologists, East Lansing
Michigan State Medical Society, East Lansing
Michigan State University, East Lansing
National Institute for Burn Medicine, Ann Arbor
Orthopaedic Guild, St. Joseph
Public Health Consortium, Ann Arbor
Southwest Michigan Area Health Education, Kalamazoo
Upjohn Company, Kalamazoo
Wayne State University, Detroit
West Shore Consortium for CME, Manistee

Hospitals:

Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Medical Center, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic/Northern Michigan Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Center for Forensic Psychiatry, Ann Arbor
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center - Branch County, Coldwater
Cottage Hospital, Grosse Pointe Farms
Crittenton Hospital, Rochester
Dickinson County Memorial Hospital, Iron Mountain
Edward W. Sparrow, Lansing
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Gratiot Community Hospital, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Herrick Memorial Hospital, Tecumseh
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital, Kalamazoo
Leila Hospital & Health Center, Battle Creek
Marquette General Hospital, Marquette
McAuley Health Center, Ann Arbor
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Midland Hospital Center, Midland
Mt. Carmel Mercy Hospital & Medical Center, Detroit
Munson Medical Center, Medical Staff, Traverse City
North Detroit General Hospital, Detroit
Northville Regional Psychiatric Hospital, Northville
Oakwood Hospital, Dearborn
Outer Drive Hospital, Lincoln Park
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Port Huron Hospital, Port Huron
Portage View Hospital, Hancock
Providence Hospital, Southfield
Saginaw Cooperative Hospital, Inc., Saginaw
Saratoga General Hospital, Detroit
Sinai Hospital - Detroit, Detroit
Southwest Detroit Hospital, Detroit
Southwest Michigan Area Health Education, Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital (East & West), Mt. Clemens
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Lawrence Hospital, CME Department, Lansing
St. Mary Hospital, Medical Staff, Livonia
St. Mary's Hospital, Grand Rapids
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University of Michigan Medical Center, Ann Arbor
Upjohn Company, Experimental Medical & Clinical Research Laboratory, Kalamazoo
VA Hospital, Battle Creek
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Approved for 9 hours Continuing Medical Education Category I credit

DEATHS

Ira Avrin, MD
Southfield

Ira Avrin, MD, Southfield general practitioner, died August 3 at the age of 66. Doctor Avrin received his medical degree from Wayne State University in 1942, then served for five years with the United States Coast Guard Public Health Department. He opened his general practice after his military discharge. Doctor Avrin was a member of the American Association of Occupational Physicians, and Phi Delta Epsilon medical fraternity.

John T. Geneczko, Sr., MD
Bay City

John T. Geneczko, Sr., MD, Bay City, died August 17. He was 58. Doctor Geneczko, an anesthesiologist, was chief of anesthesiology at Bay Medical Center at the time of his death. He earned his MD at Thomas Jefferson Medical School in Philadelphia in 1951. A co-founder of Michigan Physicians Mutual Liability Company, Doctor Geneczko was a diplomate of the American Board of Anesthesiologists, past president of Michigan Anesthesiologists, and past president of the Bay-Arenac-Iosco Counties Medical Society. He was affiliated with Bay City General and Mercy hospitals, and served in the US Army Medical Corps during World War II.

Henry T. Holt, MD
Rochester

Henry T. Holt, MD, Rochester, died August 8. He was 76. Doctor Holt was head of sports medicine at Wayne State University, and served as team physician for all WSU athletic teams. He graduated from the U-M Medical School in 1933, and specialized in surgery. Doctor Holt was a member of the Association of Military Surgeons, the Academy of General Practice, and the American College Health Association. He was affiliated with Harper, Providence, Detroit Memorial, and Cottage hospitals, and served in the US Army as a captain from 1941 until 1942.

Philip J. Huber, MD
Royal Oak

Philip J. Huber, MD, Royal Oak, died August 15 at the age of 62. Doctor Huber, former chief of neurology at Beaumont Hospital, was a 1944 graduate of the Columbia University College of Physicians and Surgeons. He served on the staffs of Harper, Children's and Beaumont hospitals until his 1978 retirement. A former member of the Wayne County Medical Society Council, Doctor Huber was a member of the Detroit Surgical Society, the American Society of Neurological Surgeons, the Harvey Cushing Society, the Detroit

Continued on page 602

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Academy of Medicine, the American College of Surgeons, and the Detroit Medical Club. He served for two years in the US Army Medical Corps.

David C. Packard, MD
Orchard Lake

David C. Packard, MD, Orchard Lake obstetrician/gynecologist, died July 28 at the age of 55. Doctor Packard earned his medical degree at Baylor University College of Medicine in 1957, and has been affiliated with Pontiac General Hospital. He was a member of the Pontiac Elks, the Knights of Columbus, the Pope John XXIII Council, the Governor General Michigan Mayflower Society, the AMA, the American College of Obstetricians and Gynecologists, and Phi Beta Pi medical fraternity. Doctor Packard trained parrots as a hobby, and served in the US Air Force from 1959 until 1961.

Dominador A. Soriano, MD
Stevensville

Dominador A. Soriano, MD, Stevensville, died April 9 at the age of 76. Doctor Soriano earned his MD in 1947 at the Loyola University School of Medicine, and had been affiliated with Central Michigan Community Hospital, Mt. Pleasant. He was a member of the American Society of Anesthesiologists, the Wayne County Society of Anesthesiologists, the Illinois Society of Anesthesiologists, the Far East Society of Anesthesiologists (Manila), and the US Forces Society of Anesthesiologists. He served in the US Air Force for eight years, and in the US Army for two years.

George L. Waldbott, MD
Leonard

George L. Waldbott, MD, Leonard, died July 20. He was 84. Doctor Waldbott, an allergy specialist, maintained a practice in Troy until his death. He had been a leader in the fight to eliminate fluoride in drinking water, and authored several articles on that subject. He graduated from the University of Heidelberg Medical School in Germany in 1921, and was founder and chief of the allergy clinics in four Detroit hospitals. Doctor Waldbott was an emeritus physician at Harper Hospital, and an honorary physician at Hutzel Hospital. He was past president of the Michigan Branch of the American College of Chest Physicians, a member of the American Academy of Allergy, founder and secretary of the International Society for Flouride Research and editor of its journal. He also was a member of the Air Pollution committee of the American College of Chest Physicians. He received an achievement award from the American College of Allergists in 1977.

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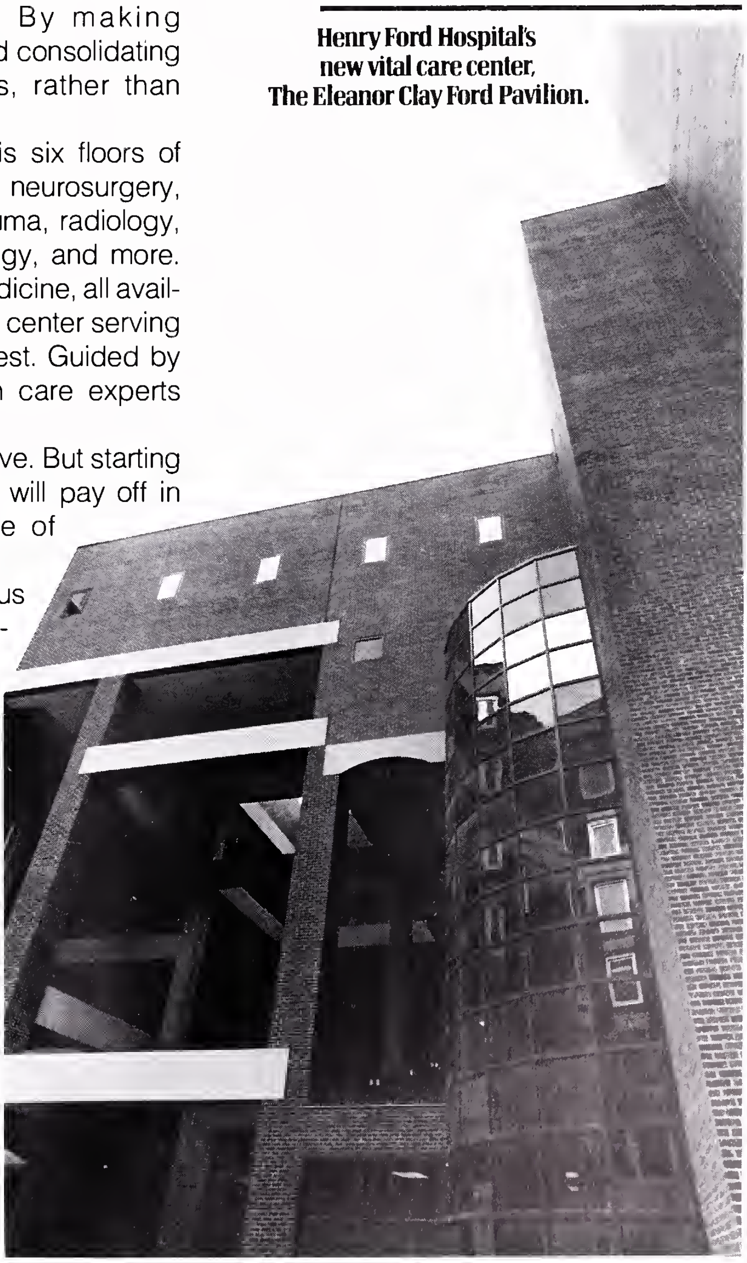

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The rate for each classified advertisement in *Michigan Medicine* is 15¢ per word, with a minimum charge of $7.50. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

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OPHTHALMOLOGIST FULL-TIME, OR PART-TIME, 2 to 3 days a week, outstanding opportunity to join busy practice in suburb of Detroit. Reply to Box 35, Michigan Medicine, 120 W. Saginaw, East Lansing, MI 48823.

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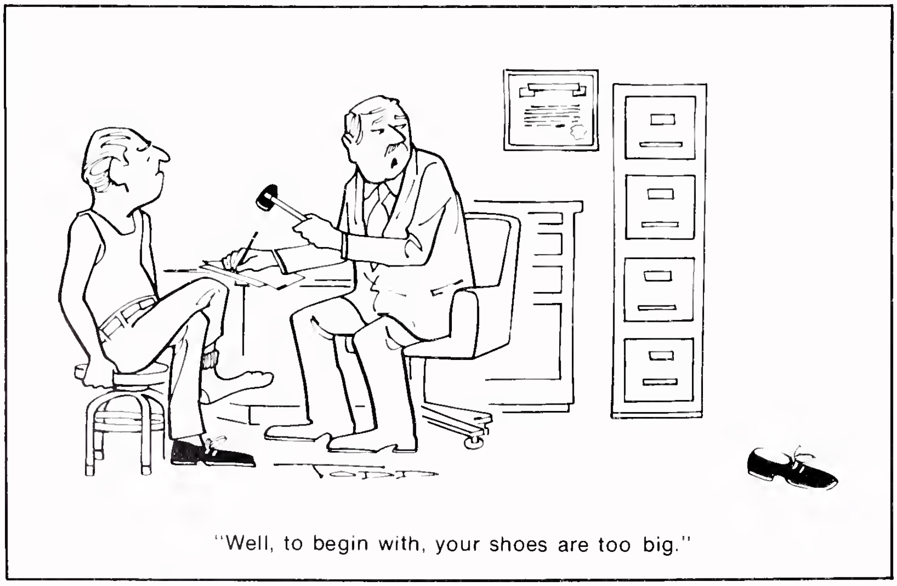

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Butterworth Hosp.	597
CBC Labs	570, 571
Health Care News	602
Henry Ford Hosp.	603
Lab. of Clinical Med.	594
Lilly	573
Medical Protective	600
MPMLC	580, 581
MSMS Annual Scien. Mtg.	IFC
MSMS Program to Asst. Imp. Phys.	582
National Bank of Detroit	583
Oakland Med-Dent Seminars	584
PICOM	595
Research Industries	559
Roche	548, 549, 561, 562, 576, 577, 578, 588, 589, 590, IBC, BC
Stratton-Cheeseman	585
Upjohn	587
US Air Force	596
Wayne State University	599

Annual Scientific Meeting chance to meet, learn with peers

Frank Cox, MD, Chairman
MSMS Annual Scientific Meeting Task Force

MSMS President James H. Tisdel, MD, Port Huron, gives space this month to a guest column by Doctor Cox, who is completing his term as chairman of the MSMS Annual Scientific Meeting Task Force.

Have you made your plans to attend the 1982 MSMS Annual Scientific Meeting Nov. 9-10-11 at the Hyatt Regency Dearborn?

If not, be sure you do so soon; for the three-day MSMS event really is a worthwhile scientific meeting for everyone.

Registrations have been coming in for a month now, and some courses are filling. If you want a good selection, don't let any more time go by before you fill out the registration form (see page 557) and send in your fees.

I really feel this meeting is a bargain. Courses cost just $6 per credit hour for MSMS members. The maximum cost for the three day conference for a member is $108, far below most CME opportunities of equal duration and quality. Other costs are $12 per credit hour for non-members, $5 per course for resident physicians and $3 per credit hour for retired MSMS members.

The Annual Scientific Meeting is a good opportunity for member of our profession to get together to update themselves and meet their peers. The opportunities abound for professional and social interplay. And, really, it is a good time.

We have tried to provide, within reasonable limits, something for everyone. So there is a balance, with a little for everyone and some in-depth probing of particular areas.

In the past two years that I have been chairman, we also have tried to emphasize the "hands-on," practical involvement of the audience in the course discussion. As an example, this year's course, "Common Nephrological Problems," with Nathan W. Levin, MD, Detroit, as course director, will begin with a didactic session. It will break into small group discussions and then bring the entire group together to review their breakout sessions.

Other courses which will take this approach will include those on "Pulmonary Function Studies and Arterial Blood Gases," and another entitled, "The Advancing Technology Parade in Ophthalmology."

We are very fortunate to have on our task force participants from all parts of the state, with a variety of scientific and educational representations. It has been very pleasant working with that group.

Each committee member brings a certain point of view to our deliberations. They are a diverse group and I think they have comported themselves very well. I have really appreciated the tremendous opportunity and privilege of working with such a talented group in my two year term. Being a chairman is fun when you have producers like that.

By way of a "thank you," I list them and their affiliations here so they may receive the recognition they deserve. My able task force members are:

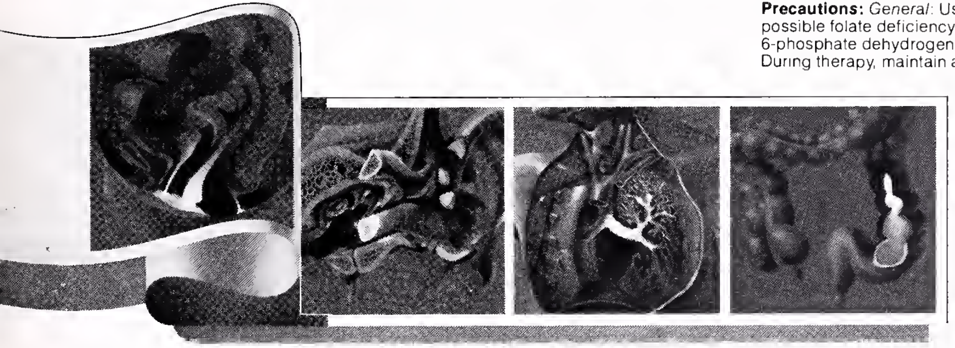
Denis F. Cash, MD, Flint, Medical Director, GM Parts Division
Edward Cotton, MD, Marcellus family physician
Kenneth L. Krabbenhoft, MD, Detroit, Radiologist, Detroit Receiving Hospital
David R. Rovner, MD, East Lansing, Endocrinology, MSU College of Human Medicine
Joan C. Stryker, MD, Detroit, Obstetrics-Gynecology, Hutzel Hospital
Julian T. Hoff, MD, Neurosurgery, U-M Medical School

Attached to this page is your copy of the new "MSMS at Work," the brochure describing MSMS leaders and programs. Share your copy with a non-member colleague and bring him or her into the fellowship of your state medical society. Extra copies are available from Mert Scholten, MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823.

Bactrim™
(trimethoprim and sulfamethoxazole/Roche)
succeeds

Expanding its usefulness in antimicrobial therapy

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):



in recurrent UTI... a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children... effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults... clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis... faster relief of diarrhea than with ampicillin[2]

BACTRIM™ (trimethoprim and sulfamethoxazole/Roche)
Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment. Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

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PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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in recurrent urinary tract infections*

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160 mg trimethoprim and 800 mg sulfamethoxazole
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1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

maximizes results with B.I.D. convenience

ROCHE®

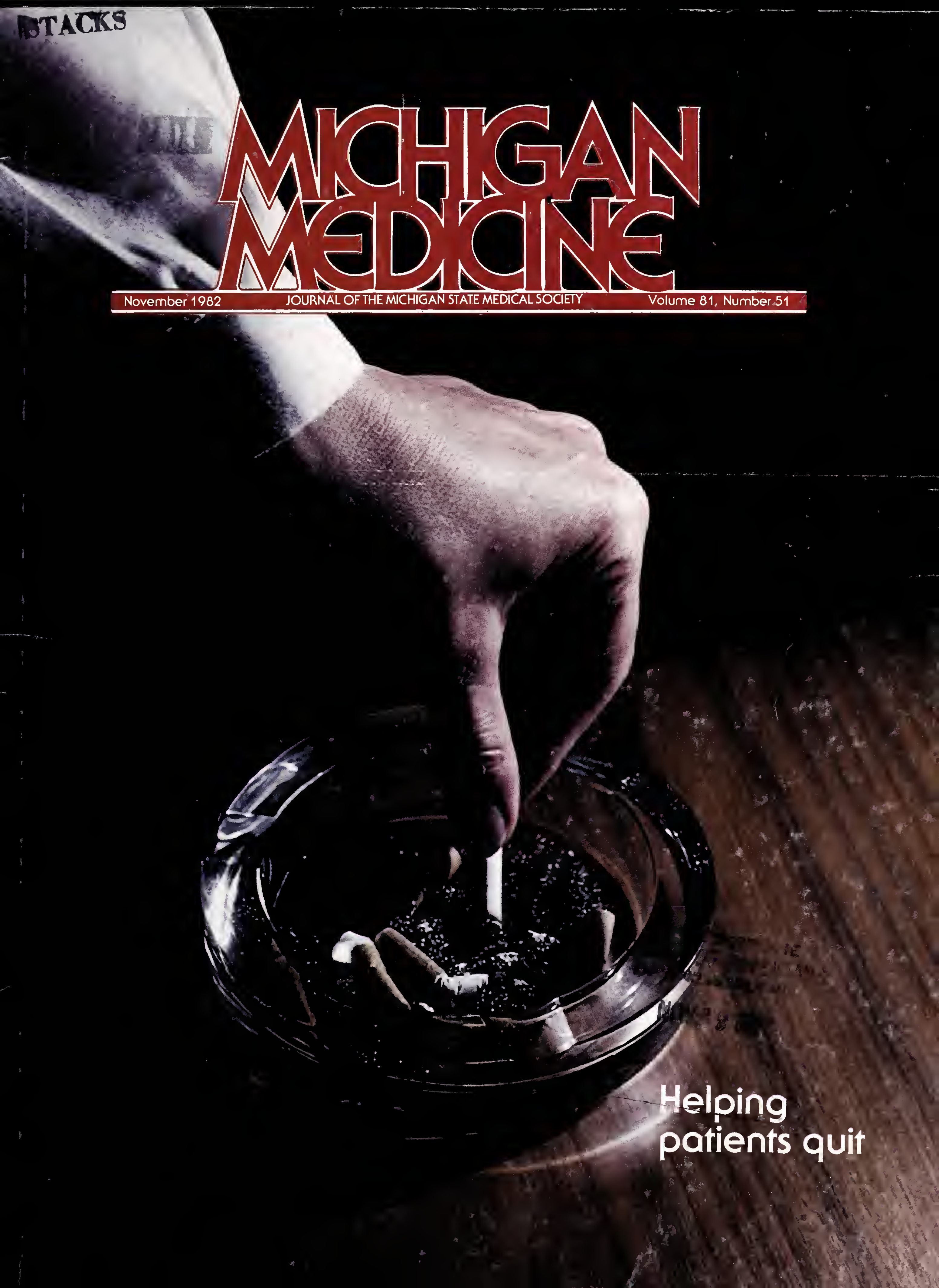
*due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

STACKS

MICHIGAN MEDICINE

November 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 81, Number 51



Helping
patients quit

MSMS Judicial Commission announces voluntary code on physician advertising

(Adopted by the Judicial Commission, Michigan State Medical Society, September 15, 1982)

Physicians who wish to advertise their practices may take advantage of the following new guidelines approved by the MSMS Judicial Commission. The guidelines are voluntary, and are designed to ensure that physicians' advertisements are tasteful, ethical and effective. They were approved Sept. 15 after a year of deliberation by the Commission, chaired by Harold Machin, MD, Kalamazoo. This page may be removed from the magazine and saved for future reference.

The Judicial Commission of the Michigan State Medical Society recognizes that the US Supreme Court rulings and the written opinion of the Michigan Attorney General make it permissible for physicians to advertise the availability of their services, so long as the advertisements do not contain false, misleading or deceptive material.

Because of these rulings, the Judicial Commission offers the following information with the intention of providing guidelines for members of the Michigan State Medical Society who choose to advertise. The use of these guidelines is entirely voluntary on the part of any individual physician.

- It is appropriate to advertise the availability of physicians' services in the public media, at the location where such professional services are rendered, or by the issuance of business or appointment cards.
- Public media include any commercial publications or other means of communication with the public, including newspapers, magazines, telephone directories, radio, television or other advertising.
- When using electronic media, remember the impressions perceived are often fleeting and misinterpreted. Thus it is suggested and recommended that this type of advertising should be pre-recorded and approved by the practitioner. A recording of the actual transmission should be retained by the practitioner.
- Advertisements are expected to be in good taste. If the physician has any concern as to the appropriateness of his proposed advertisement, he or she is urged to consult with the appropriate officers and committees of the local medical society.
- It is recommended that professional advertising provide:

A. General information such as name, title, home and office address, telephone numbers, answering service, office hours, and changes in office hours, absence from or return to practice, and additions or deletions from professional license staff.

B. Professional information such as degrees earned, board certification, areas of specialization, limitation of professional practice, type of practice, professional affiliation, hospital affiliation, and foreign language competence.

C. Fee information such as usual and customary fees for routine professional services, notification that fees may be adjusted due to complications or unforeseen circumstances, and which third party payers are recognized.

- It is considered inappropriate for a physician to engage in advertising relating to:

A. Testimonials and/or anecdotal reports of successes by the practitioner or claims of superior quality of care to entice the public.

B. Fee comparisons with other practitioners licensed under the medical practice act.

- Physicians should not engage in:

A. Advertising professional services which the practitioner is not licensed to perform.

B. Advertising which contains false, fraudulent, deceptive, or misleading material, warranties or guarantees of success.

Thank you for not smoking

Provided by
Michigan State Medical Society

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COLLEGE OF PHYSICIANS
OF PHILADELPHIA
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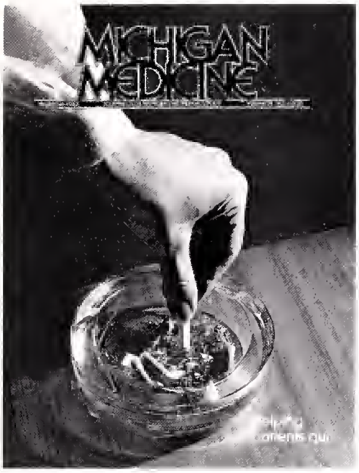


When your patients stub out that last cigarette, they may need help in refraining from lighting up again. This issue is designed to help the doctor know where to turn for that help. **(Cover photo by Mert Scholten, MSMS staff)**

MICHIGAN MEDICINE

November 1982, Volume 81, Number 51

Special report

614 You have convinced your patient to stop smoking. Now what do you do?

There are a wide variety of programs available to the person who wants to kick the habit. To help the physician in pointing the way, *Michigan Medicine* this month describes many of the Michigan programs and how they operate. E. Joseph Alberding, MD; Joseph Arends, MD; Mark Campbell, MD; and Sandra Gross.

Features

IFC New MSMS advertising code

624 MSMS launches new voluntary perinatal care guidelines; Joseph Moore, MD

627 PPO newest health care delivery structure; Deborah Zannoth

631 How to analyze and meet your potential practice market: another in the series of "Meeting the Challenge of the 80's"

650 Don't risk your professionalism on poor telephone techniques; K.L. Christenson, MD

Departments

610 In my opinion; Harvey M. Andre, MD

611 Letters

630 Financial planning; Daniel Ludwin

638 Views; Thomas R. Berglund, MD; Rhoda M. Powsner, MD

648 News; Sheri W. Greenhoe

656 Category I courses

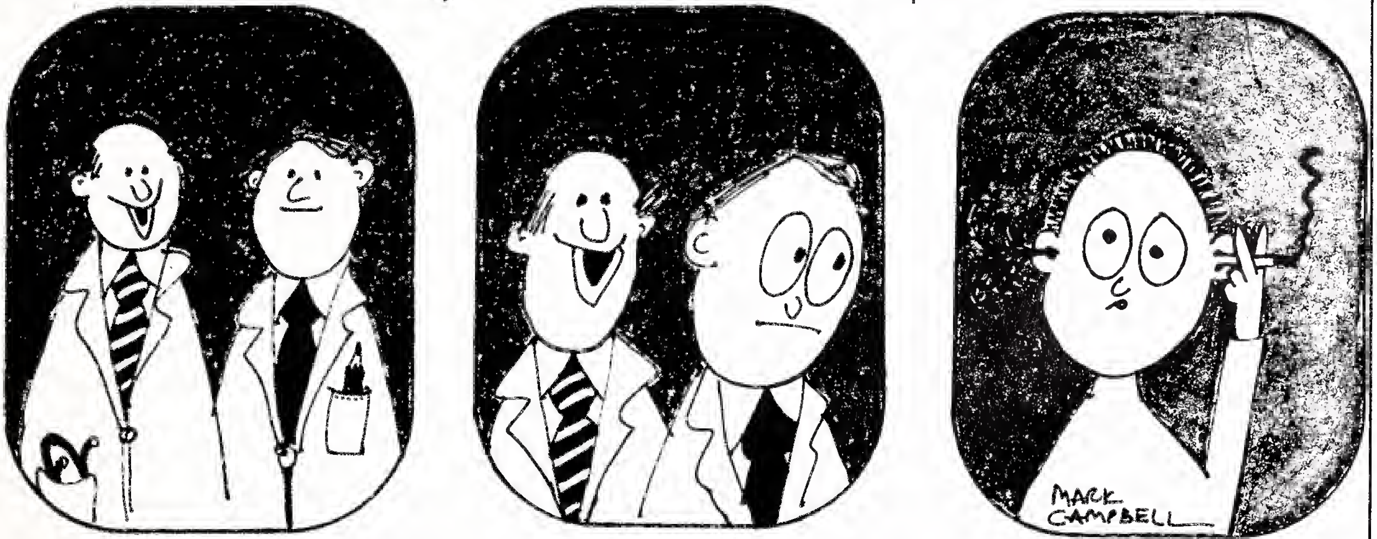
658 Deaths

660 Classified ads

661 Ad index

662 President's page; James H. Tisdel, MD

Doctor Quickdraw



"I told him he had to quit smoking if we were going to be able to save his lungs."

" . . . but I think I underestimated his nicotine addition . . . "

IN MY OPINION

Another bad habit — failure to communicate

By Harvey M. Andre, MD
Grand Rapids

This issue of *Michigan Medicine* is devoted to the ill effects of smoking — a bad habit. This message is directed to another bad habit — the failure of physicians to fully explain to patients what the doctor's diagnosis is of the patient's particular problem, and how he plans to treat it, and why he is pursuing this course. In my present position, as a disability evaluator, the most common complaint I hear from those I examine is: "my doctor never took time to explain things to me."

Years ago the physician was almost regarded as a little "god" and often a well sounded "umm" or an "ah ha" was sufficient to satisfy the patient. That day has long gone, and every physician should recognize that fact.

Some physicians are just too busy — with patients scheduled too tightly in an allotted time, to really talk with their patients. Others still think of themselves as a little "god" and seem to feel it beneath their dignity to explain in simple terms what is wrong with a patient, what they plan to do about it, and *why!*

The "why" is just as important as the diagnosis. So often I hear the complaint, "my doctor tried first one medicine, then another, then another, and nothing did any good." In expressing these feelings then, the patient gives the impression that the doctor just did not know what he was doing. They are resentful.

This situation easily can be avoided by explaining *beforehand* that different people react differently to various drugs and it may be necessary to try several to find the one most effective for that particular individual. Also, don't forget to mention possible side effects, and instruct the patient to call you, or discontinue the drug if these side effects appear.

Another problem is discussing the types of treatment pursued. Don't promise what you cannot deliver, and be sure the patient is well informed of possible complications, not in gory detail, but at least mentioning them as a possibility — not probability.

One way to try to have your patients understand their problem is to use plastic models of the diseased part, or use simple pictures or drawings. Make a note on the chart that these aids were used — it surely helps to have this recorded should you be involved in a malpractice suit.

This message is to stress one thing only — communication with your patient — done in a simple manner, without the use of medical terminology as much as possible. Simple explanation builds patient confidence and respect, and avoids the bad habit of lack of communication.

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Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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LETTERS

World Medical Relief

Do you remember the August *Michigan Medicine* articles on World Medical Relief and its dynamic 85-year-old president Irene Auberlin? Support of that good organization is a personal cause of MSMS President James A. Tisdel, MD, who appreciates WMR's efforts to send surplus medical equipment and supplies to physicians and clinics serving the needy of the world. In the following letter, he calls on component medical societies to aid World Medical Relief.

Several months ago I had the opportunity to tour the headquarters of the World Medical Relief, Inc. and meet the president, Mrs. Irene Auberlin. What I saw impressed me so that I requested *Michigan Medicine* to do a feature story on the work being done by this remarkable woman and her organization. I have enclosed a copy of the article which appeared in the August issue of the Journal.

World Medical Relief, Inc. operates almost totally on donations and discards from the health care industry. Volunteers salvage medical supplies, repair medical equipment, sort discarded pharmaceuticals by type and expiration date and ship them in containers resurrected from discarded piano crates. The organization has the necessary physicians, pharmacies, nurses and other personnel to meet the state, national, international requirements for shipping pharmaceuticals and medical supplies. The result is that literally tons of medical supplies and equipment that would have been discarded have been recycled to meet national and international health care needs. The magnitude of this feat is magnified by the fact that World Medical Relief, Inc. doesn't receive any governmental support. It is a stellar example of a successful private sector voluntary initiative.

I am writing to request that you consider how your county medical society, jointly and as individuals, can contribute to this effort. In many counties the medical auxiliary is already working with World Medical Relief, Inc. by collecting the unwanted medical supplies and equipment from physician's offices. This has proven to be a very productive arrangement.

Whatever contribution you can make, whether it is a few pharmaceutical samples or the office equipment of a retiring physician, I can assure you that it will be put to good use. I request that you use your position of leadership to make physicians aware of this opportunity to meet the health care needs of the medically indigent.

James M. Tisdel, MD
MSMS President

Nuclear war

Doctor Fryfogle's article (*Michigan Medicine* 88:468, '82) dealing with a review of the medical consequences of nuclear weapons and nuclear war fails to consider several points which strike me as being important.

(1) "There have always been wars, and there always will be." An old adage.

(2) "History repeats itself," another old adage.

(3) The Japanese bombed Pearl Harbor.

(4) The Truman decision to employ nuclear weapons at Hiroshima and Nagasaki saved thousands of American lives.

(5) Soviet policy is world domination, and American policy opposes this.

(6) A medical tenet is preparedness.

The Physicians for Social Responsibility credo encompasses some assumptions which, so far, have not been tested; e.g., meaningless disaster planning, no effective civil defense, impossibility of recovery from nuclear war. Their views have been criticized by Doctor Edward Teller as presumptuous in that they are not the only ones, physicians or otherwise, who are responsible socially, morally or medically.

Moreover, we all should be concerned about statements which could lead to false security, that Russia's concerns for nuclear war consequences are real. They have, according to reports, a more highly developed civil defense than have we; they have, according to presidential statements, greater nuclear capability.

It seems unrealistic, therefore, to adopt a view that nuclear war is unwinnable, for that would lead to a greater gap than is now envisioned with resultant eventual unilateral capitulation. Had the Soviets considered up to this point peace on other than their own narrow terms, discussions at various conferences over the years would undoubtedly have produced greater progress, than has been shown up to this point.

We need to prepare to prevent, to survive. Without preparedness, military, civilian, and political as well, effective progress will falter. It is time not to tread on the flag, but to rally round. Premature dismantling of nuclear arsenals would be strategically disadvantageous; banning nuclear weapons use would place all, save for a sole non-signatory, in jeopardy (and in the case of Russia, a signature on a document is patently meaningless).

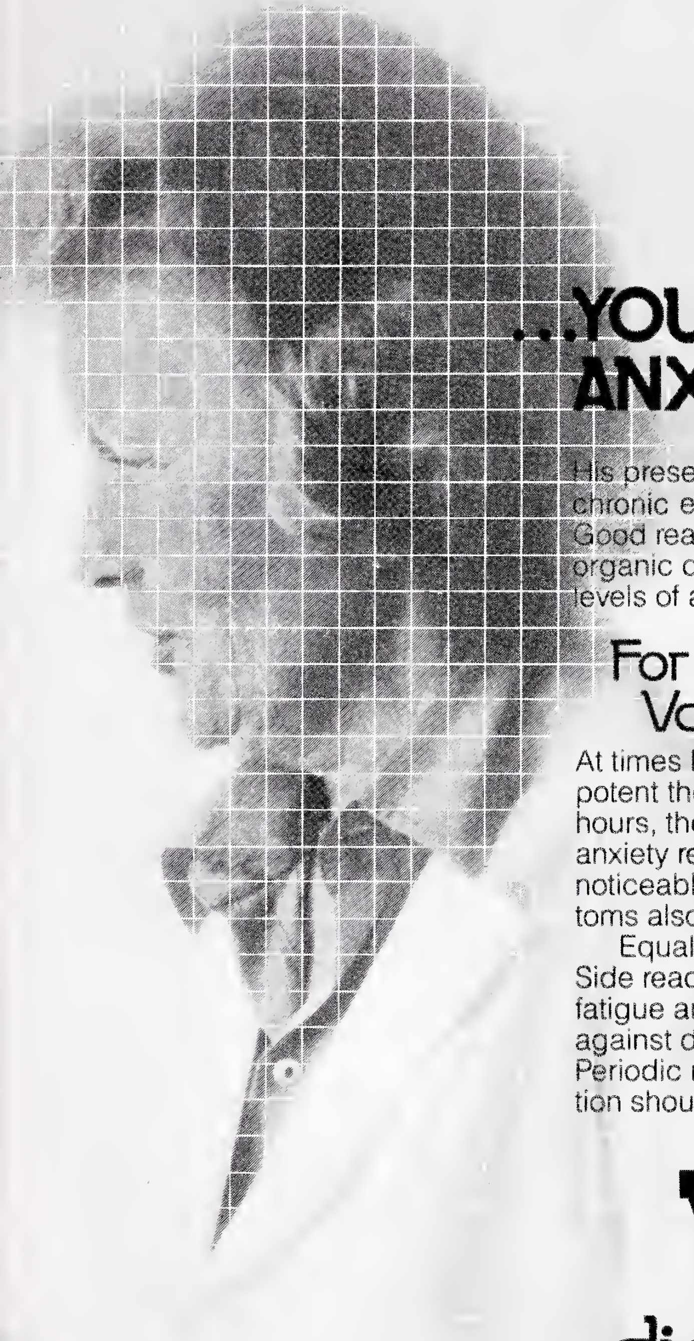
Preparedness would serve well as a signal of national will, is consistent with medical reality indicating a necessity for the profession to train to cope with unusual, as well as common, medical situations.

We must think broadly to prepare, in order to prevent, to have a chance to survive and to win.

Richard A. Wetzel, MD
Birmingham

P.S. For further discussion on this topic see the *Annals of Internal Medicine*, Sept. 1982, particularly the editorial comments enclosed thereto.

THE PATIENT THINKS HE HAS HEART TROUBLE...



...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM® ⓘⓥ

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

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Please see summary of product information on the following page.

VALIUM® (diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500,* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701
†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110

ROCHE
ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

Special report

Physicians' resources in the stop-smoking effort

By E. Joseph Alberding, MD
Portage

If an individual does not want to stop smoking, no one can force him or her to give up the habit.

After years of experience, including my own efforts to stop smoking, I still find this to be true. It is difficult for pleas and exhortations to reach someone who doesn't want to change their behavior.

It is the hope of your MSMS leaders involved in this effort, however, and that of your *Michigan Medicine* staff, that the following special report will give you a psychic nudge toward stopping smoking. The doctor must set the nonsmoking example before he or she can effectively help patients stop smoking.

This special report is designed to provide the practitioner with the tools to help patients stop smoking. Here is a roundup of the programs and printed resources available in the state to which physicians themselves can turn for aid and to which they may direct their patients.

In addition, Doctor Joseph Arends, well-known crusader against smoking, talks about the physician's role in this effort, and the approaches which have worked best in his experience. Physician-cartoonist Mark Campbell, MD, adds his own touches, and Michigan's pending indoor clear-air legislation is described.

Behind all this effort is the following official stance of the Michigan State Medical Society, formed over the years by the MSMS House of Delegates:

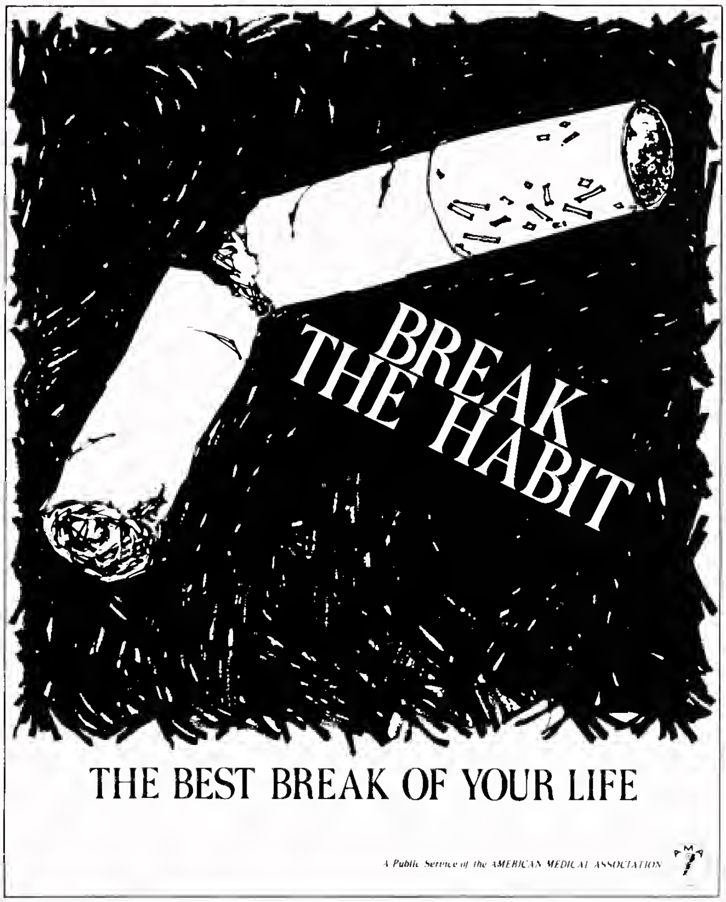
"MSMS encourages its members to reflect their knowledge of the hazards of smoking by personally stopping smoking.

"MSMS encourages its members to encourage their individual employees and hospital staff members to stop smoking.

"MSMS encourages its members to work to ban the sale of tobacco products in all hospitals and health facilities.

"MSMS urges members to avail themselves of all opportunities to lead or participate in the dissemination of information regarding the hazards of smoking, cooperating with existing agencies of like goals."

Doctor Alberding is a family physician and chairman of the MSMS Liaison Committee with the Michigan Department of Public Health.


BREAK THE HABIT
THE BEST BREAK OF YOUR LIFE
A Public Service of the AMERICAN MEDICAL ASSOCIATION

How to help patients quit

By Joseph Arends, MD
Troy

The first concept for the practicing physician to comprehend is that the strongest motivating force to alter behavior is the personal example of the physician. If the physician smokes any form of tobacco, any attempts to motivate patients will fall on deaf ears.

The next step beyond personal example is to take a smoking history, which also should include alcohol, caffeine and possible drug abuse histories. Frequently, these are common lifestyle patterns. The physician must judge which of these abusive behavior patterns is more immediate, and work on it first, and deal with only one problem at a time.

I would suggest that any smoker over the age of 30 should have pulmonary function examinations at least every two years; and if they have a productive cough they should have sputum cytology annually. Often an elevated white blood cell count or sedimentation rate can be a tip-off to chronic bronchitis in a heavy cigarette smoker when there is no other obvious source of infection. These kinds of tangible physical changes get attention.

If there is one important lesson that I have learned from patients it is that changing human behavior is very difficult. Change must come in small, incremental stages. The physician is not just trying to have the patient stop smoking: the physician is trying to change the patient's whole life philosophy.

Patients commonly ask, "Where do I start?" A patient who is 30 pounds overweight, drinking excessive alcohol and smoking cigarettes and who has failed to quit smoking before is a defeatist. They have been unsuccessful in the past because they have been impatient and have expected too much too soon. Our role is to focus upon only one or two behavior changes at a time and to support their efforts in a positive fashion.

The answer to where to start is to start with an exercise program. The goal is to replace negative habits with positive habits.

I suggest having people walk one mile in 18 minutes, at a minimum of three times per week, assuming that there is no clinical evidence of coronary heart disease and no other similar contraindication. If you can convince the patient to achieve this positive goal of improvement, this change in lifestyle assumes other value judgments. It generally means that they are managing their time and judging that they deserve a certain minimal amount of activity for their well-being. I strongly suggest that the physician make a contract with the patient, and pick specific days and specific times for this exercise. If this kind of appointment schedule is not set initially, follow through is unsuccessful. Exercise times must fit the personality (morning or afternoon) and must fit that person's schedule. A definite pattern of endurance exercise three times per week is the first step.

". . . the strongest motivating force to alter behavior is the personal example of the physician."

The next step is the full support of the spouse, which is critical for success. If the spouse does not join the patient in stopping smoking, success is very limited.

Then, you must discuss avoiding those friends and settings which are temptations to smoking, such as bowling nights, card playing nights or other similar social engagements.

Our younger females are better informed now than 20 years ago, yet they continue to smoke. Health belief alone is not enough; peer pressure and peer interaction are stronger motivating forces. In addition, their short-term fear of weight gain overcomes long-term health considerations. Perhaps we should focus on stained teeth and bad breath.

Third, the physician must seek out those areas of high emotional stress which lead the individual back to the nicotine habit. Whether it is career, finances, marriage, child rearing or in-laws, the areas of high stress must be identified and controlled.

A fresh look at the smoking problem

By Mark Campbell, MD
Grand Rapids

It is estimated that 85 percent of lung cancer is due to cigarette smoking. Cigarette smoking is a major cause of cancer of the larynx, oral cavity, and esophagus as well as a contributing factor for the development of cancer of the bladder, pancreas and kidney.

Cigarette smokers have increased morbidity and mortality caused by arteriosclerotic heart disease and chronic pulmonary disease.

Each physician individually may not be able to fight the tobacco lobby, or overcome the immense pharmacologic, psychologic and social causes for cigarette addiction, but perhaps we can make a small, subtle, yet meaningful statement to our patients by insisting that there be NO SMOKING in our offices. The smokers may not see this as a concern for their preventative health care, but I am sure the non-smokers will appreciate the fresh air.

Doctor Campbell is an oncologist and cartoonist.

DOCTOR ARENDS/*Continued*

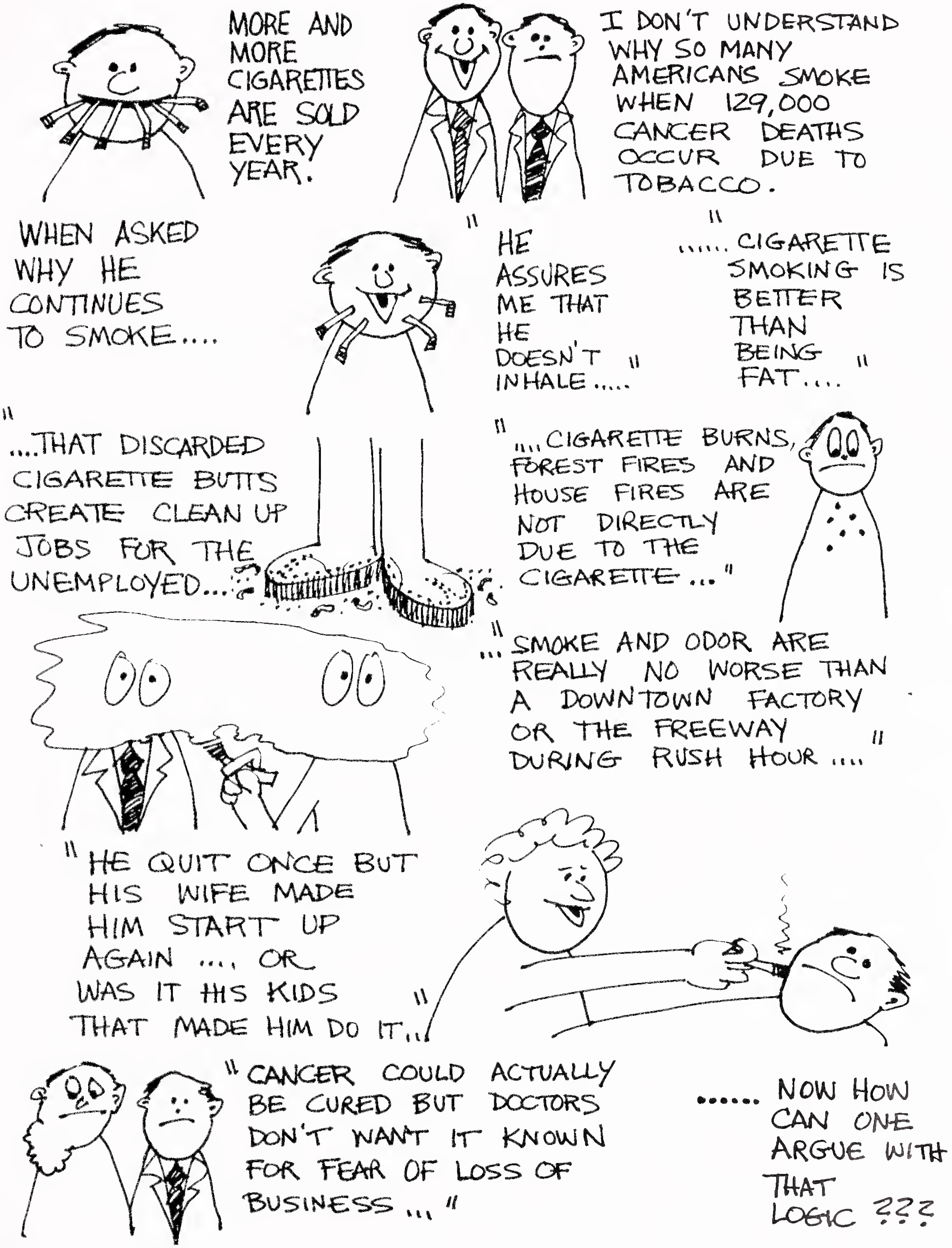
There are other elements concerned with tobacco addiction, such as the strong habit reflex of caffeine and cigarettes. If this should be a problem then the procedure is as follows: Three months after implementing the exercise, peer support, stress control program the person needs to cut down to a maximum of 200 mgs. of caffeine per day (one cup of brewed or two cups of instant or 10 cups of decaffeinated coffee). However, if the patient finds that any amount of coffee triggers a desire for a cigarette, then coffee must be eliminated. They may require nicotine gum as an adjunct to the early stages of tobacco withdrawal.

Once the elements of a consistent physical activity program, peer support and stress control have been implemented, then eventually the patient will be able to obviate their nicotine habit. It may take six months, two or four years, but eventually with the adoption of these better life habits they will judge for themselves that smoking makes no sense. Although slow cigarette withdrawal may work for some females, males usually only respond to abrupt withdrawal.

We all are familiar with other alternatives such as Smoke-Enders and hypnosis routines. But my experience is that people who are successful with these programs are those who are already motivated enough to spend relatively large amounts of money to want to quit smoking. It is not the particular program or the hypnosis that is effecting the withdrawal. My experience has been that these programs may have some benefit for approximately three to six months, but these kinds of passive approaches do not work long term, unless the participant actually pursues positive improvement (exercise). Studies are clear that ex-smokers who develop and follow a regular exercise program have a much better rate of staying off cigarettes than non-exercisers.

Maybe the most important message for the physician is not to become frustrated and give up. It is difficult for those of us who do not smoke to understand how truly addicting cigarette smoking can be.

The message is to be positive, supportive and patient.


MORE AND MORE CIGARETTES ARE SOLD EVERY YEAR.
I DON'T UNDERSTAND WHY SO MANY AMERICANS SMOKE WHEN 129,000 CANCER DEATHS OCCUR DUE TO TOBACCO.
WHEN ASKED WHY HE CONTINUES TO SMOKE....
" HE ASSURES ME THAT HE DOESN'T INHALE....."
" ......CIGARETTE SMOKING IS BETTER THAN BEING FAT...."
" ....THAT DISCARDED CIGARETTE BUTTS CREATE CLEAN UP JOBS FOR THE UNEMPLOYED..."
" ....CIGARETTE BURNS, FOREST FIRES AND HOUSE FIRES ARE NOT DIRECTLY DUE TO THE CIGARETTE..."
"...SMOKE AND ODOR ARE REALLY NO WORSE THAN A DOWNTOWN FACTORY OR THE FREEWAY DURING RUSH HOUR...."
" HE QUIT ONCE BUT HIS WIFE MADE HIM START UP AGAIN ...., OR WAS IT HIS KIDS THAT MADE HIM DO IT..."
" CANCER COULD ACTUALLY BE CURED BUT DOCTORS DON'T WANT IT KNOWN FOR FEAR OF LOSS OF BUSINESS..."
...... NOW HOW CAN ONE ARGUE WITH THAT LOGIC ???

An overview of smoking cessation programs in Michigan

By Sandra Gross
East Lansing

Don R. Powell, Ph.D., "What Physicians Can Do About Smoking Cessation," speech presented at the AMA Scientific Meeting, San Antonio, Texas, January 12, 1980.

"The physician is in a unique position to help patients to quit smoking cigarettes. He is viewed as an authority figure with a broad knowledge base. He is a role model with whom patients attempt to identify. He is seen as one who is totally invested in the patients' good health but, unlike family members, can be objective in offering suggestions. Finally, physicians have the highest quit rate and the lowest smoking incidence of all professionals, which makes their anti-smoking advice highly credible. . . If physicians routinely provided information about the harmful effects of smoking and the benefits of quitting, advised their patients to stop, and offered suggestions on how to do so, many more patients would discontinue their habits."

Ms. Gross is a Lansing area freelance writer/editor.

In his speech, Doctor Powell also reminded physicians of their responsibility to inform patients how to quit on their own, to offer group or individual cessation counseling, or to refer them to a reputable clinic. The 1982 Surgeon General Report argues that having physicians advise their patients to quit might be the most cost-effective manner to bring it about. About clinics, the report specifies the need for maintenance in a natural environment and the need for programs to deal with both the behavioral and cognitive cures that brought about the habit and to rely on group support.

In addition to familiarizing themselves with the programs reviewed here, physicians could contact local university medical or psychiatric departments, health departments and hospitals which may offer their own programs through their health promotion, patient education, or community outreach divisions.

Smoking cessation programs offered in Michigan are sponsored by public and private, nonprofit and profit agencies. (Acupuncture and hypnosis have not been included here.) Patients are usually concerned with the cost and the problem of weight gain. Thus, most programs deal with the potential of weight gain by including nutrition, exercise, and eating management as part of a new lifestyle. Most of the programs offered cost half what it takes to support a pack-a-day habit (figuring $250 a year for cigarettes and another $150 for increased health and insurance costs and miscellaneous expenses).

A description of the programs includes the method and materials used, where they are offered, the schedule and cost, and the name of a contact person. Frequency of clinic offerings varies. Three sample programs not affiliated with those surveyed — one at a university, another at a hospital, and one which is a statewide physician organization — concludes the roundup.

FreshStart
American Cancer Society

The Michigan Division of the American Cancer Society (ACS) offers its FreshStart program at many of its county units. In addition, local units refer individuals to programs sponsored by ACS in churches, community facilities, or hospitals. ACS programs are offered at the VA Hospital in Ann Arbor, Beaumont Hospital in Royal Oak, and St. Mary's Hospital in Grand Rapids.

Clinics are designed to give smokers the skills to stop. The approach is pragmatic and no-nonsense and actively uses behavior modification and group interaction. Participants are asked to stop quickly and stay "stopped" by focusing their energy on not returning to the habit. The facilitator is a nonsmoker or quitter of more than six months committed to good self-care and good group dynamics.

The program includes a participant workbook and audiovisual materials, and addresses thoughts and behaviors. An essential component of the program is planning ahead. To achieve long-term benefits, stress management, physical improvement and weight control are also included.

The four one-hour sessions cover a two-week period and most are offered evenings, although some are given as brown-bag lunch sessions. The cost is minimal, ranging from $0-$25 to cover expenses. Contact your local American Cancer Society or:

Dorothy Cobb
Director of Public Education
American Cancer Society
Michigan Division, Inc.
1205 East Saginaw
Lansing, MI 48906
(517) 371-2920

Freedom from Smoking American Lung Association

The American Lung Association of Michigan offers its Freedom from Smoking program at regional clinics in Ann Arbor, Grand Rapids, Kalamazoo, Marquette, Saginaw, Traverse City, and Flint.' Two manuals are available for smokers who would prefer a self-help program. Clinics also are given at local health departments, community centers, business locations, and service organizations.

The ACS program is based on the premise that smoking is a learned habit. Material has been developed for the program by doctors and psychologists. The clinics, run by volunteers, employ an instructor's manual, audiovisual materials, and handouts for participants.

The approach is systematic and designed to make quitting less stressful. Participants learn to identify their own smoking behavior and to substitute other healthful activities after quitting cold turkey. The seven-week program meets one and a half hours per week and requires a $35 nonrefundable fee. The manuals can be ordered by sending in a $7 contribution.

Manual #1, *Freedom from Smoking in 20 Days*, guides the smoker in daily activities to cut down consumption gradually. In a highly individualized and personal manner, smokers are led to recognize the elements determining their particular smoking pattern and what actions should be taken to break their habit. Manual #2, *A Lifetime of Freedom from Smoking*, comprises the maintenance component to keep quitters "quit." It shows them how to deal with tension, feelings, and social situations that may lure them back to smoking. Continued help and a self-reward system reinforce the new nonsmoking lifestyle.

For more information on clinics in your area, or to order the manuals, call 1-800-292-5979 or write:

Karen Krzanowsky
Program Coordinator
American Lung Association
of Michigan
403 Seymour Avenue
Lansing, MI 48914

Stop Smoking System American Health Foundation

The American Health Foundation, funded by a Mahoney Foundation grant, offers its Stop Smoking System in corporate settings and through hospitals in southeastern Michigan. Hospital settings include Oakwood Hospital in Dearborn, Botsford Hospital in Farmington Hills, Hurley Medical Center in Flint, Health Central in Lansing, St. Joseph Hospital in Mt. Clemens, St. Joseph Mercy Hospital in Pontiac, Providence Hospital in Southfield, Riverside Hospital in Trenton, and Bi-County Community Hospital in Warren.

The Stop Smoking System is a five-day multiple-treatment approach to teach smokers the skills and techniques to prevent and eliminate the urges for cigarettes. The behavior management technique of the program and its programmed manual are based on a social, psychological, and physiological perspective. It focuses on stimulus control, incompatible behavior, cognitive coping, mental imagery, behavior reversal, self-reward, and eating management.

The free introductory phase is given for an hour in the evening to introduce the would-be quitter to the program. Those who wish to continue are given an initial assignment to be completed a week later. The treatment phase then begins with four consecutive evening meetings for one and a half hours each (in a corporate setting, one-hour sessions at lunch).

The maintenance phase is third and is held for one hour once a week up to four weeks following withdrawal. Those unable to attend maintenance sessions are given a self-help manual with 25 messages to reinforce the motivation to stay off cigarettes. The cost varies from $125-$130 per participant (less for health maintenance organizations and corporations). For further information about the Stop Smoking System, contact:

Dr. Don R. Powell
Regional Director
Division of Health
Promotion Services
American Health Foundation
3000 Town Center, Suite 2900
Southfield, MI 48075
(313) 352-7666

Smoke Stoppers

Smoke Stoppers, a private corporation, offers its program to corporate clients and through selected medical institutions. Its first affiliation was with the McCauley Health Center in Ann Arbor and it continues there. Programs are available at Leila Hospital and Health Center in Battle Creek, Mecosta County General Hospital in Big Rapids, Henry Ford Hospital in Detroit, Flint Osteopathic Hospital, Grand Rapids Osteopathic Hospital, Borgess Medical Center in Kalamazoo, Foote Memorial Hospital in Jackson, and Psychological Services in Petoskey.

Staff and instructors all are former smokers who seek to break an unintentional self-destructive cycle within a group format. The strategies employed reflect the various elements which lead to smoking. Smoke Stoppers is a three-phase program running over a five-week period. A free introductory hour seminar is given during the preparation stage, usually on a Monday or Tuesday evening. Smokers are given an assignment for the following week, should they decide to enroll.

Phase 2 is held on four consecutive days or evenings for one and a half hours each to learn the skills necessary to stop. These sensory blitzing sessions are designed to eliminate the imagined benefits of smoking. Powerful negative smoking exercises conclude each session: fast puffing without inhalation or smoking cigarettes covered with a repugnant substance. Instructors wear gas masks or respirators while participants "enjoy" smoking. The final phase runs an hour a week over a three-week period and provides a smooth transition to a healthier nonsmoking lifestyle. The transition phase deals with nutrition awareness, eating management, and stress control.

The cost varies from $100-$150 per participant with reductions for full-time students and medically disabled seniors. Those who resume smoking can repeat the whole course or segments of it free of charge. For further information, contact:

Wendell Haight
Program Director
Smoke Stoppers
Huron Towers
Suite 201 W. Tower
Ann Arbor, MI 48105
(313) 994-3329

Smokenders

Smokenders, a commercial program accredited by the Council for Noncollegiate Continuing Education, offers its program at convenient locations — motels, hotels, and schools. Sessions have been offered in Ann Arbor, Detroit, Flint, Grand Rapids, Kalamazoo, and Lansing and have been given to hospitals, corporations, religious groups, and educational institutions. Generally, programs are offered three times a year in one city and four times a year in the Detroit area.

Based on the premise that smoking is physically and psychologically addictive and is a learned habit, Smokenders uses a highly structured program with little room for deviation. The moderators are ex-smokers who have completed the program. The program is a learning experience based on examining the causes for smoking without recourse to will power or cures. Participants, through behavior modification, reasoning, and mutual support, gain a sense of personal growth and understanding. The basic physical addiction to nicotine is addressed as well as the emotional basis and social problems. The message is transmitted in a positive and pleasant manner without aversion therapy or scare tactics of death and disease. A weight-control component is built in. Sessions attempted to motivate smokers and cliff-hanging techniques make them want to return to the next session.

In their Log books, participants record concepts that have been unlearned: smoking is not attractive or virile, nor does it lead to relaxation. They sign an agreement not to reveal "the guts" of the course and this contract provides a bond. Smokenders deals with the causes of the habit and spends time to effect change.

The program lasts eight weeks for two hours a week, usually evenings. After the first five weeks, when smokers can smoke all they want, they are ready psychologically and physically to quit. Some will have reduced voluntarily by that point. The remaining three weeks reinforce the new lifestyle. Tuition rates vary with reductions offered to groups and corporate clients. For further information, call 1-800-323-1126 or write:

Phelps Nichols
Regional Office
Smokenders
800 Roosevelt Road
P.O. Box 3146
Glen Ellyn, IL 60137

Five-Day Plan Seventh Day Adventists

The temperance division of the Seventh Day Adventists offer a Five-Day Plan to Stop Smoking using the cold turkey method. Clinics are held throughout Michigan at sponsoring churches and are open to the general public. A team made up of a pastor and a physician (not always a church member) leads the group. The pastor addresses the spiritual and motivational aspects while the physician focuses on the physical aspects and promotes a healthy lifestyle. Films made by the heart and cancer societies and by the church enable participants to see the effects of smoking in a realistic manner and to provide the motivation to quit. Others deal with general motivation and show the effects of losing a family member who smoked. The goal is to bring about a better way of life through exercise and better eating and to show participants that if they can break one habit, they can break others.

Total withdrawal is to be endured through willpower and relaxation. Participants are advised to take hot and cold showers; to get enough sleep; to abstain from alcohol and caffeine, stimulants and sedatives; to eat in a more healthy manner by eliminating meats, fats, and sugars, and substituting fruits and vegetables; and to drink large quantities of liquids. To develop will power, participants are asked to remind themselves that they have chosen not to smoke and divine aid is relied upon as a source of will power.

The program runs for five days, one and a half hours in the evening, and requires a nominal charge to cover the materials and the facility. For further information, locate the pastor of the local church through the phone directory (there are 160 Seventh Day Adventist churches in Michigan); otherwise, contact:

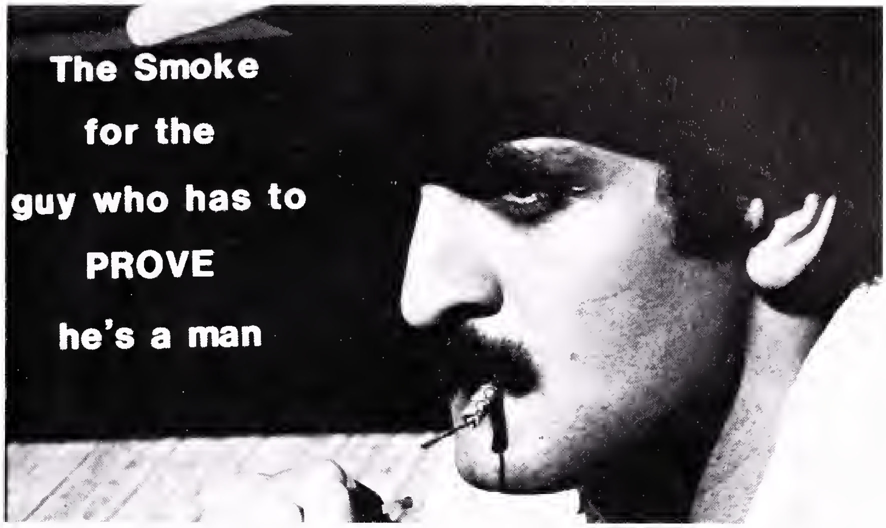
Meryl Fleming
Michigan Conference of
Seventh Day Adventists
P.O. Box 19009
Lansing, MI 48901

Smoking Withdrawal Clinic E.W. Sparrow Hospital

Sparrow Hospital in Lansing offers the Greater Lansing Smoking Withdrawal Clinic modeled on alcoholism programs. Offered five times a year, the clinic features mutual group support under guided leadership. The leaders are graduates of the program who have demonstrated leadership ability. Four to five times monthly, audiovisual aids from the lung and cancer societies are shown and professionals — doctors, nutritionists, radiologists, and thoracic surgeons — make presentations to the group.

The clinic meets three times a week for two hours on Monday, Wednesday, and Friday evenings over a four-week period. The charge is $30. Further information can be obtained from:

Helen Carpenter
Coordinator
(517) 487-3817



A DOC'OM anti-smoking advertisement.

DOC'OM

Although not a treatment program, DOC'OM provides an opportunity for the physician to get involved at the grass roots level, providing the public with information about health risks such as cigarette smoking and reaching teenagers. Our July 1982 issue featured an article on Doctors Ought to Care of Michigan. Should you wish to become a member or sponsor a program in your community contact:

Mike Klinkman, MD
c/o DOC'OM
775 Main Street
Chelsea, MI 48118

The following three examples are programs independent of the groups detailed above. Michigan State University's Department of Psychiatry has taken its pilot program "It Pays to Stop Smoking" to several worksites. The researchers argue that it is better to reach a greater pool of potential quitters and to assist them in a familiar environment without the necessity of intense professional involvement as may be required by clinics. To provide powerful inducements to quit, the program uses financial incentives and builds on the social support group at work and outside. Smokers are organized into teams to generate esprit de corps. Contracts are drawn up and shown to coworkers, relatives and friends.

The program lasts over six months and hourly meetings are held during work hours. Participants view films from local heart, lung, and cancer societies which show the effects of smoking. After a month, smokers choose their method of reduction. After the second month, discussion focuses on the benefits of living well and maintaining a healthy lifestyle. The contact person is:

Dr. Thomas Stachnik
Department of Psychiatry
A-222 E. Fee Hall
Michigan State University
Lansing, MI 48824

Clean Indoor Air Act opportunity for physicians

By Sen. Jack Faxon
Lansing

As a legislator intent on upholding my constitutional responsibility to safeguard the public's health, I have sponsored a Michigan Clean Indoor Air Act, Senate Bill 486.

SB 486 would restrict smoking in public places, including the work place, to designated smoking areas. I am thoroughly convinced that indoor air pollution is a serious health hazard which the legislature should address much in the same way as Congress has set standards for clean outdoor air.

After years of research into the phenomenon of passive smoking, science is learning that the health of nonsmokers is impaired as a result of their exposure over time to sidestream cigarette smoke.

Surgeon General C. Everett Koop recently issued a report reaffirming what we already know: namely that cigarette smoking is the chief preventable cause of death in America. However, Doctor Koop went further and warned that involuntary or passive smoking is a real, if not proven, health risk and consequently nonsmokers should avoid being in "smoke filled rooms."

Michigan's own Legislative Office of Science Advisor has reported to the Legislature that the federal standards for outdoor air are routinely violated indoors where people smoke.

Nevertheless, this conclusion, which was echoed in a research study conducted by James L. Repace of the Environmental Protection Agency and Alfred H. Lowrey, a chemist with the Naval Research Laboratory in Washington, should not be too startling in 1982. On April 17, 1975, *The New England Journal of Medicine* reported that in crowded rooms "concentrations of tobacco smoke often exceed 260 mg per cubic meter, the federal air-quality standard for particulate matter that is not to be exceeded more than one day per year." (Findings of William C. Hinds and Melvin W. First)

Finally, according to the research team of James R. White and Doctor Herman F. Froeb at the University of California in San Diego, there is no significant difference in the lung damage of the passive smoker, the smoker who does not inhale, and the light smoker. In other words, a nonsmoker who becomes a passive smoker at work or in public places may inhale the equivalent of between one to 10 cigarettes per day.

Passive smokers who want to alleviate the deleterious effect of sidestream smoke have been attacked as zealots by the tobacco industry. In spite of the small number of firms involved, the industry has been able to generate sufficient opposition to keep Senate Bill 486 from coming to a vote in the Senate Labor and Retirement Committee.

Industry spokespersons have maintained that the goal of limiting smoking in public places should be left to personal courtesy and not to the law. Perhaps no act of government infuriates us more than the feeling that our personal lives are being invaded by the law. This feeling is healthy in a democracy, if its citizens are to preserve their personal liberty.

However, the scientific studies which I have noted have begun to document a perception of smoking that moves it beyond the realm of personal choice and into the arena of social regulation. When a smoker imposes a preventable health hazard on a person who chooses not to smoke, then one must ask the question of whether nonsmokers have the right to challenge the causes of indoor smoke pollution.

I believe that the state essentially is committed under law to seek what is good for society, such as protecting the health of those who choose not to inflict carcinogenic harm upon their bodies. Senate Bill 486 intends to advance this social good and in this regard comports with the goal of the medical profession to keep humans free from disease.

Since the dawn of civilization, society's healers have devoted their wisdom and power to the eradication of sickness and disease. I call upon today's medical professionals who have inherited this noble tradition of healing to lead the general public as well as government on a journey of health. In affirming life over the stale, decaying waste smoke makes of the air we all must breathe, Senate Bill 486 represents a lone oasis on the way to wholeness.

Sex. Faxon is chairman of the Senate Committee on Education. His bill currently is in the Senate Committee on Environmental and Agricultural Affairs.

End to smoking primary MDPH concern

The Michigan Department of public Health is actively involved in helping educators and health care professionals learn to aid persons who wish to stop smoking.

- In 1980, The Governor's Citizens' Panel on Smoking and Health recommended 19 actions to be carried out by the State to decrease the incidence of smoking by Michigan citizens. The panel worked under the knowledge expressed by Gov. Milliken in his 1980 State of the State message that, ". . . smoking is cited as the greatest single preventable cause of death in America today."
- In 1980-81, the Department funded five major health education-risk reduction intervention projects in local areas, most of them aimed at reducing the incidence of smoking by youth and adolescents.
- In June, 1982, the Department staged a three-day conference to provide local health department and hospital personnel with health promotion skills for smoking cessation, as well as for stress management and weight control.

Though the state's poor fiscal condition has curtailed further educational efforts, Sunny Fong Chiu, acting chief, Division of Health Education and Communications, emphasizes that smoking cessation continues to be a primary concern of the department.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia, may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Better care of high-risk mother and infant goal of MSMS regionalized guidelines

By Joseph Moore, MD
Grand Rapids

Doctor Moore

The Michigan State Medical Society Committee on Maternal and Perinatal Health has long had as a goal minimizing the risks to the pregnant woman and her fetus and improving the outcome of the pregnancy for the mother and newborn relative to morbidity and mortality. The impetus towards regionalization of perinatal care grew out of this goal and an ad hoc committee was formed to actively pursue regionalization.

At the outset, the ad hoc committee was very ably chaired by James R. Irwin, MD, of Grand Rapids. Under his direction, review teams were formed which surveyed 39 hospitals supplying various levels of obstetrical care in Michigan. The goal was to gain information from these on-site reviews to determine reasonable steps to regionalization of perinatal care. The committee used "Toward Improving the Outcome of Pregnancy" published by the National Foundation — March of Dimes in 1976, as a model document.

Improved care

We then sent copies of a draft document to a variety of organizations and invited them to meet with us to express their feelings. The organizations invited included: Michigan Hospital Association, the Michigan Section of the American College of Obstetricians and Gynecologists, the Michigan Chapter of the American Academy of Pediatrics, Blue Cross Blue Shield of Michigan, the Michigan Academy of Family Practice, the Greater Detroit Area Hospital Council, Incorporated, the Michigan Association of Osteopathic Physicians and Surgeons, the Michigan Nurses Association, the Perinatal Association of Michigan, the Consumer Task Force on the Childbearing Years and the West Michigan Health Services Agency.

These meetings engendered very lively discussions and negotiations resulting in numerous modifications of the document. However, at the conclusion of these meetings, we had gained the general approval and support of these organizations for the Guidelines for Regionalized Perinatal Care.

Why would we go through the process of developing guidelines for regionalized perinatal care? Much effort was expended and much time was spent. First, we anticipate improved perinatal health care with resultant decrease in perinatal mortality. Second, such a document may be very helpful in local health planning. The development of medically appropriate standards in a community is simplified by having such a format available. Finally, these guidelines are very useful in the implementation of perinatal services.

The structure for regionalizing perinatal care is straightforward. The state is divided into regions. Within each region, there is a referral center so designated because of the presence of a neonatal intensive care unit. These centers are designed to serve populations; therefore some will encompass very small geographic areas while others encompass very large areas. While referral patterns may be suggested, in no way is it anticipated that already existing referral patterns are to be changed or restructured. MSMS is adamant that the guidelines be used on a voluntary basis. The goal was to assure access to perinatal services to the residents of the state.

Common goal

Why is there a need for hospitals to join in this effort? First, all hospitals delivering obstetrical care share a common goal, that of reducing risk to the mother, the fetus and the newborn, thereby decreasing infant morbidity and mortality. Second, the advances of modern technology with its inherent expenses have mandated concentration of these technologies in larger hospitals. Third, these technologies should be as available to the patient (and physician) in a hospital having 300 deliveries a year as they are in a hospital having 300 deliveries a month. Regionalization of care offers a way in which this might be accomplished.

The regional center, by working with these technologies on a daily basis, will develop a certain expertise in their usage. In turn, this knowledge must be disseminated to the other hospitals in the region through outreach education, through protocols for patient care and referral (developed in concert with the referring hospitals) and through inservice programs in the referral center.

Both the referring hospital and the regional center share responsibility for exchanging information relative to their unique needs, sharing in patient care and working together to provide optimal care for the mother, the fetus and the newborn. Through such cooperative effort we may expect to see the Guidelines for Regionalization of Perinatal Care play an increasingly important role in improving perinatal health care with diminishing infant mortality.

Doctor Moore is chairman of the Subcommittee on Obstetrical and Neonatal Planning of the MSMS Committee on Maternal and Perinatal Health.

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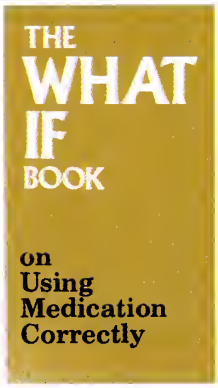
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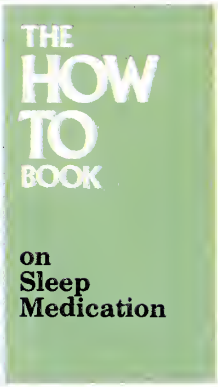
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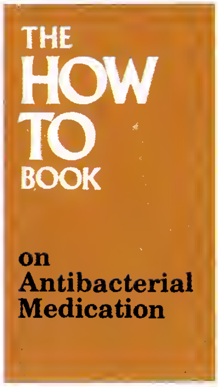
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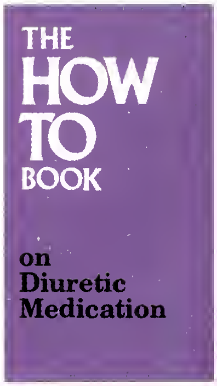
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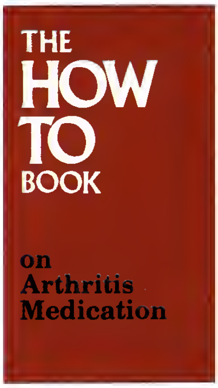
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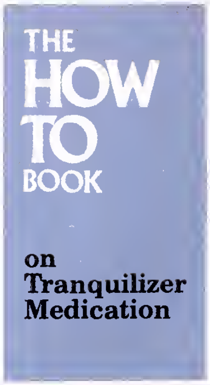
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PPO 'newest kid on the block' in health care delivery systems

By Deborah Zannoth
East Lansing

PPO's are the "newest kids on the block" among alternative health care delivery systems. Therefore, Michigan physicians would be wise to obtain at least a rudimentary understanding of how PPOs work. To that end, here is a brief description. The bulk of the information in this article is from a report, "An Introduction to Preferred Provider Organizations," by Linda Krane Ellwein and David D. Gregg, MD, of Interstudy, the Minnesota health care think tank. The report was written in February, 1982, and was revised in April and June.

The PPO first appeared early in the 1980's in the West. PPOs appear to be a response of traditional health care providers to increasing competition in the local market. They have developed in areas where competition and rising costs are evident. The examples have occurred in cities such as Denver, Los Angeles, San Diego, Dallas and Houston, which have a surplus of physicians and a rapidly growing HMO population.

The PPO design is quite simple. Each group consists of a panel of providers, hospitals and physicians in various combinations. The agreement which binds providers and subscribers is that each time a designated service is provided by the panel, it is provided at a previously agreed-upon fee. There is no prepayment or capitated amount for providers as in a health maintenance organization. With the promise of many financial rewards, consumers are encouraged to seek a preferred provider each time for health services. Incentives includes a waiver of copayments and deductibles or improved benefits.

Each form of PPO has developed a somewhat different shape, but does share a number of common characteristics.

- A limited grouping of physicians and hospitals agrees to specified discounted fees. (We don't know of any plans which are capitated.)
- Consumers are not locked in to those providers, but if they receive services through the listed providers, copayment and deductibles are eliminated and/or benefits increased.
- Benefits levels are flexible.
- Usually includes a program of utilization review and a management information system which provides cost and use data for employers and trust funds.
- Relatively low administrative costs.
- Rapid turnaround on claims, so that providers are paid very quickly.

The initial PPO was born in Denver, where three groups have contracts with 15 multi-employer union trust funds. PPOs cost practically nothing to start and administrative costs hover around six or seven percent. Employers like them not only because of the discount rate (perhaps 20 percent below the usual and customary fee), but because they also can develop their own benefit package.

Ms. Zannoth is assistant to the MSMS Bureau of Economics.

PPO activity in Michigan

The preferred provider organization (PPO) first appeared in Michigan as a health care benefit plan for the Michigan Conference of the Teamsters Welfare Fund.

To date, 50 percent of the total Teamster membership is involved in the Plan A (Gold Plan) package. The plan developed exclusively for the Teamsters by the Delaware Professional Services Corporation is currently operating more than 60 family health centers throughout Michigan.

Plan A entitles the subscriber to access a complete staff of doctors, nurses and medical professionals at various medical centers all over Michigan. Below is a list of some of the benefits included under Plan A:

1) Free comprehensive annual physicals for you and your spouse.
2) Free school or camp physicals for your children.
3) Free preventive innoculations.
4) Free member additional life insurance up to $5,000.
5) Personalized Teamster Gold Health Card.
6) Weight loss clinics.
7) Non-smoking clinics.
8) Fitness and nutrition clinics
9) Family counseling.
10) Specialty referrals.
11) Maximum charge of $4 per office visit for out-patient care.
12) No deductibles.
13) No claim forms.
14) No waiting periods.
15) Total flexibility: you may leave Plan A at any time simply by notifying your Fund office.

At an Aug. 18 meeting of MSMS, Wayne County Medical Society and Teamsters Welfare Fund representatives, the Teamsters remarked that the union was offering the Plan A option to members as an alternative system to control costs.

A negotiated price is acceptable to providers for several reasons: rapid turnaround on claims for attractive cash flow maintenance, participation which enlarges the patient base and the PPO design which creates a minimal financial risk.

The fee schedule negotiated is not necessarily a discount but an attempt to create a more uniform price for services delivered by a designated group of providers. Employers will be seeking overall cost savings by directing a significant proportion of employees to cost-effective physicians and hospitals.

Providers in a PPO are still being reimbursed on the fee-for-service concept. However, if a PPO is to be successful in reducing health care costs it has two alternatives:

1) To select physicians and hospitals known to be conservative and cost effective in delivering care.

2) To rely on control mechanisms to eliminate unnecessary services.

Current methods of utilization control vary widely among PPOs. Some are hospital initiated; some are influenced by employers, others by third party claims review. Regardless of design, control of utilization is one of the PPO's strongest marketing features.

Other effective cost containment mechanisms which often are features of a PPO are:

1) Primary care physician directing patient care

2) Emphasis on outpatient and ambulatory services

3) Hospitalization only when absolutely necessary

4) Pre-admission certification

At this time it is unclear what mechanisms are used to determine a preferred provider and the process by which physicians become involved in a PPO.

The PPO is most definitely a hybrid that appears similar to an HMO-IPA but offers benefits comparable to those of a conventional commercial health plan. Employers will have little reason to contract with a PPO in a competitive marketplace if they are not proven to reduce total patient care costs. Certainly they are an interesting addition to the health care delivery system and will continue to be monitored with great fascination by the health care community.

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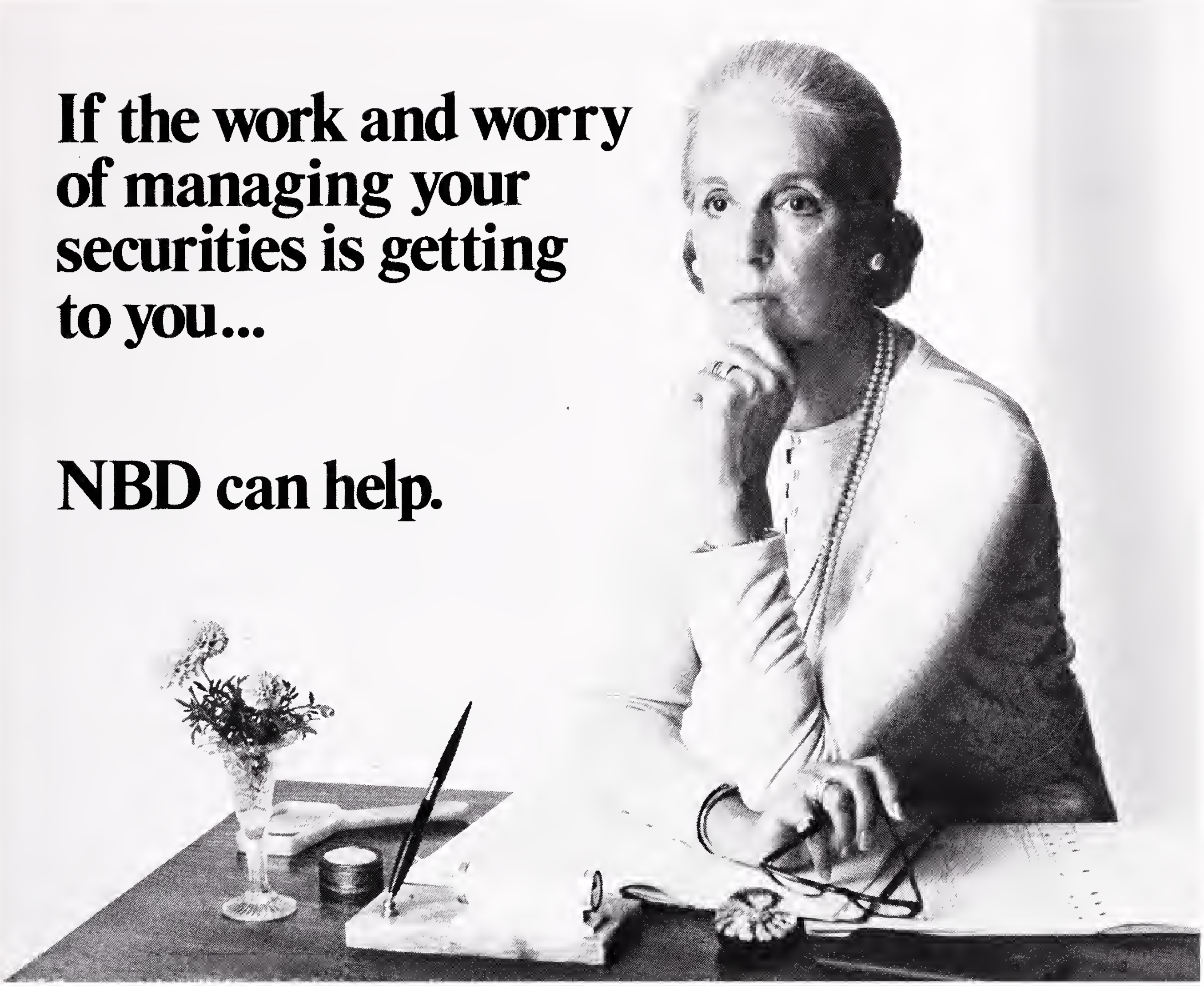

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FINANCIAL PLANNING/ INVESTMENT PERSPECTIVES

A tax-shelter primer

By Daniel Ludwin
East Lansing

During recent years, tax advantaged products have enjoyed a tremendous popularity. This month's article is an overview of this complicated and highly individualized area. During the next year we will review many of these products and their applications in much greater detail.

In order to begin our primer, we must first review some of the basic reasons for investing in tax advantaged products (TAPs) and some of the pitfalls associated with them. Then we'll divide these TAPs into two categories and discuss their differences. And finally we'll list several examples of TAPs by categories.

Some dos and don'ts

There are three basic reasons for investing in TAPs. They are:

- To *convert* ordinary income into long-term capital gains.
- To *defer* current income or current tax liability into future years; and
- To *create* tax-sheltered cash flow.

Coincidentally, there are a few things you must not do:

1. *Don't overshelter* your income; sheltering income at the 40 percent tax bracket (or below) and paying it later in the 50 percent bracket.
2. *Don't overinvest* in one product; diversify your investments in this area just as you would your stock or bond portfolio.
3. *Don't wait* until year-end (now you tell me!) to begin looking for TAPs — most quality limited partnerships offer a number of programs throughout the year. This also will help you diversify.

TAPs can be divided into two broad categories. The first we'll call economic tax investments and the second, deferral/write-off tax investments. Each, when used properly, can offer the investor certain advantages.

Economic tax investments

These TAPs primarily are purchased for their economic viability. The investor is anticipating a real return on his capital. Along with this hope, he will receive some first year deductions. Generally, they will range between 50 percent to 85 percent of his initial investment. Below are listed some of these Economic Tax Investments along with their expected deductability and anticipated return (if successful!).

ETI	Approximate Initial Deductability	Anticipated Return	Average Life
Oil and gas (development)	50%-75%	1.5-2.5	6-8 yrs.
Oil and gas (exploratory)	65%-90%	1.5-3.5	7-12 yrs.
Movie (diversified program)	60%	2.5-4.0	3-4 yrs.
Real estate (com. income)	10%-15%	*10%/yr. + 2.5	6-8 yrs.
Equipment Lease (income)	10%-15%	*15%/yr. + 1.0	7-9 yrs.

**Annual cash flow*

Deferral/write-off tax investments

The return on these TAPs is based principally on the tax dollars saved/write-off received. They are generally very sophisticated investments and require close work with your tax advisor. But for the right investor, they can be a very helpful financial planning tool.

Remember, we are simply deferring the taxes into future years. How we invest that "interest free loan" (taxes saved) from the government really dictates most of our investment return.

The write-off associated with these TAPs will range from a ratio 2:1 to as high as 3.5:1. For example, a first year investment of $10,000 might give you a deduction that year of $35,000 resulting in a tax savings of $17,500 (remember, this is a deferral!). Normally, these "deals" require an ongoing cash investment over a period of three to five years, with corresponding large deductions during the pay-in period.

After the pay-in, some deals continue to generate deductions for a few more years without any further cash contributions. Eventually, however, most of these investments begin to generate "phantom income." Phantom income is reportable, taxable income — without cash! In other words, it's time to start paying back that "interest free loan" the government gave us. The amount of phantom income will, of course, vary from deal to deal, but remember *it is there*.

Typical investments in this category would include: real estate (subsidized housing); equipment leasing; and real estate (leveraged, leaseback).

Mr. Ludwin is senior vice president of Prescott, Ball and Turben, investment bankers and brokers, East Lansing. He is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve funds assets. He has 15 years' experience in the financial field.

Meeting the challenge of the 80's

Toward a flourishing medical practice: analyzing and meeting market objectives

Building and maintaining a patient base is of major importance to any physician in private practice. Few physicians would deny the need to have a steady flow of patients, including a significant number of new ones, passing through their offices. Yet, mention the value of developing a marketing plan and many doctors will react as if some particularly vile odor had assailed their nostrils.

What causes this aversion by physicians to a process which is generally considered essential by persons in every other field? Perhaps it is merely a matter of semantics. It is likely that the term "practice building" would be much better received. But why should physicians, who are, after all, proprietors of businesses as well as professional practitioners shy away from the terminology of business? Perhaps some of the older physicians remember the not-so-subtle comments in the doctor's lounge when a colleague was "zinged" for an appearance on television or an article in the newspaper. Overt "practice building" was, at one time, considered unethical. But those days are past and the competitive era of the '80s is upon us.

Perhaps a definition of marketing — as opposed to selling or advertising — will be useful in determining the degree to which a physician should become involved in such endeavors. Simply stated, marketing is the process by which a specific group of potential consumers of a product or service are identified and motivated to purchase that product or service.

The use of research techniques to identify the targets for this process has tended to cloak the marketing process in statistical mysticism. The great passion for esoterica that pervades the field of marketing has caused some persons to consider it the province only of highly trained experts. In reality, much of marketing is reasonably straightforward and adaptable to even the smallest medical practice. What follows is a description of some market research and planning techniques that can be used in the operation of any physician's practice. These techniques will help determine what patients want in the way of services and will assist the physician in planning a strategy to provide the services and motivate patients to use them.

Medical marketing has some specific characteristics that must be understood and kept in mind. First of all, the use of medical services is not possible without the participation of the physician and the capacity to deliver the service must exist before any transaction can occur. Second, since the service is produced and consumed simultaneously with payment being made later, the good faith of the consumer is critical.

Because of these factors, combined with the intangible nature of most medical services, the potential consumer — or patient — must understand both the nature and the benefit of the service before it can be sold. These may seem to be quite obvious statements, yet one of the most common complaints from patients is that the physician does not take time to explain the need for or the effects of a particular course of treatment. Not surprisingly, this failure is often the basis for malpractice suits and is one of the first aspects of a medical practice that risk management consultants investigate.

The basic concept that should be kept in mind when preparing a marketing plan is that it requires two-way communication. Theodore Levitt, in his book *The Marketing Mode,* provides the following comparison of marketing and selling: "Selling tries to get the customer to want what the company has. Marketing tries to get the company to have what the customer wants."

Finding what the customer wants is a function of market analysis. This task is one that can be done by an individual practitioner using fairly simply information-gathering techniques, or it can be given in-depth treatment by specialists using highly sophisticated methods. The choice will largely depend on the size of the practice and the amount of time and money the physician is willing to invest.

Regardless of the plan's sophistication, there are some basic elements that any marketing scheme should include.

The first step should be the preparation of a written *mission statement*. This statement should include an objective look at where the pratice is, in terms of its operation, patient base and competition, and where it plans to be at the completion of the marketing plan. This means that the statement must be specific in terms of its goals and the time frame in which the goals are to be met. Generally, it is prudent for initial ventures to set a goal that can be achieved in six months or less. Such a mission statement might state:

"Survey 30% of active patients on a random sample basis to determine their reaction to evening hours twice a week. If results are 60% or more in favor, initiate new schedule and evaluate revenue gains resulting from this policy. Survey to be completed within 30 days and study to be implemented for six months."

A step that most physicians should take, even if nothing else is done, is to assess the current status of their practice. There are a number of facets that should be included in such an assessment.

Description of Practice. What clinical procedures are performed and which are done most frequently? Who are the practitioners involved (including paramedical staff) and what are their backgrounds? What facilities does the practice have, during what periods are they utilized, and are they up-to-date? With which hospitals and/or clinics does the practice have working relationships? What is your primary service area based on a patient origin study? What percentage of the potential patients in your area are served by your practice?

Description of Service Area. Contact local chambers of commerce and business development groups for information. How many persons and households in service area? What are the ages, income, education and percentage of two wage-earner families? Who are major employers and what are their prospects for the future? What are the mobility factors of persons in your area and how does the turnover rate compare with your practice turnover? What are the five- and ten-year projections for growth? Who are the primary holders and purveyors of capital? What is the tax status of the communities? What hospitals and out-patient clinics serve the area? What news media are there and who would be the person to contact?

Current and Potential Competitors. List all private practitioners, PAs, HMOs, hospital services and free-standing clinics that offer — or may offer — services similar to those provided by your practice. Where possible, identify by name the physicians and key paramedical professionals involved in these services. Are there other services being planned? Where will they be located and how will they operate? Summarize the strengths and weaknesses of each service and estimate the number of patients that they serve. What is the nature and frequency of promotional material produced by competitors? (Prepare a file of printed materials and include tapes of radio and television announcements.) Try to determine or estimate the amount of dollars spent by competitors in promoting their services.

Patient Profile. Prepare a listing of the practice's patients that will include the following information:

- address, age, sex, marital status, number of children
- employer and occupation (spouse also, if employed)
- initial referral source and diagnosis
- insurance or payment source
- educational and income status (if possible)

Once these data are obtained and recorded (preferably in a computer) it will be possible to prepare a composite that can be used to compare your practice against the demographic information for the service area. This comparison can often point up discrepancies and anomalies in the patterns of patient service and referral that characterize your practice. For example, if the demographic data shows that the average age of persons in your service area is 35 yet your patients are predominantly in the 50 to 60 year bracket, you will want to check the referral source of new patients to determine why you are not drawing from the primary patient pool. Plotting patients' residences on a map may show pockets of scarcity, which may indicate that persons in that area have a negative image of your practice for some reason.

Development of a market data base is particularly important if you plan to expand the size of your partnership or P.C.; open a satellite office; or offer new services. In such cases, you will probably want more information than is available from existing sources. This may lead you to consider a survey and to make a decision between conducting it yourself or hiring outside help. Generally, this decision is made on the basis of available funds and the size of the project. There is, however, no particular reason why a fact-gathering survey cannot be done internally.

The first obstacle to be overcome in preparing for a survey is the conception that people will not respond. In fact, most persons are flattered to be asked for their opinion and, assuming the survey is not too lengthy or difficult, are quite willing to participate.

Choosing a medium for conducting a survey is a matter of some importance. Since, as Vance Packard has said, "the medium is the message," there are some inherent problems with each of the survey methods. The four most common methods are group interviews, one-on-one interviews, telephone surveys, and direct mail.

Briefly, the group interview is most often used in situations where problem-solving, or concept development is the primary objective. Symbiotic relationships occur and the result is a sort of "Think Tank" which, though useful, usually will not produce results that can be projectable to an entire population.

One-on-one interviews are usually the most intensive of surveys, as well as the most expensive. They require trained interviewers who will not bias the response and they must be uniform in format so as not to skew the results by failure to give equal emphasis to each segment of the interview. By and large, personal interviews are best for relatively complex issues that require extensive and subjective responses by the interviewees.

Telephone surveys are quite popular for opinion studies because they provide a relatively inexpensive method that has quite high accuracy *if the sample is properly selected.* Political pollsters in particular have used telephone surveys with great success. They have the special advantage of rapid "turn-around" in terms of contacting and analyzing the response from a selected sample of the public. A pitfall that faces amateur survey planners is the inaccessibility of a sizable number of persons, particularly females, who have unlisted telephone numbers.

By far the most common survey technique is the direct mail questionnaire. Such a survey is especially applicable in a situation where the "universe" of persons to be contacted is relatively small and well-defined. For example, a survey directed at the patients of a general practitioner who is seeking information concerning possible new services, could very well be accomplished by direct mail. However, there are a number of issues to be addressed if the survey is to produce results that can be relied upon.

To obtain satisfactory response and reliable information from the questionnaire, there are several steps that should be followed.

First, you should clearly define the kind of information you are trying to obtain. Remember that the shorter the questionnaire, the more likely it is to be answered.

Keeping in mind the kind of information you want, prepare a list of questions that will elicit response without preconditioning the respondent. Avoid subtlety since it, like beauty, is often in the eye of the beholder. Straightforward questions will usually get response.

When you have drafted the questions, have several persons read them to evaluate their clarity. Be careful of abbreviations and use of medical jargon. Don't ask questions that require much effort to answer. To creative in your writing but avoid trying to be funny or "cute." Unless well-handled, attempts at humor can backfire.

If possible, try to show some benefit that the respondent may realize from replying. But don't reach too far and insult the recipient's intelligence.

Try to make your questionnaire interesting but be careful of using cartoons or artwork just for their decorative quality. If they help focus the respondent's attention to a point or if they illustrate a question that otherwise would require a lengthy description, it's smart to use them; otherwise, don't bother.

The design of the questionnaire should be clean and businesslike. Beware of colored ink and paper, for color can influence a person not to respond. Don't use cheap paper or printing; it costs only a little more to use good quality stock and it will pay off in responses.

It is important to be brief, but don't reduce your questionnaire in size just because someone says that nobody will respond to anything over a page in length. Multi-page questionnaires can get an excellent response if they are interesting and to the point. On the other hand, be aware that postage — both outgoing and for the reply — will be a significant cost factor. By all means, provide return postage on the reply envelope.

Your cover letter will be the most important part of the questionnaire. The letter will ideally be individually typed with an inside address and salutation and personally signed. There are companies in your area that will produce repetitive letters on your stationery if you wish. If the size of the mailing or the cost factors preclude having a personalized letter, do not bother with simulated signatures, use a memorandum form.

Keep the letter brief and "spill the beans" early by telling the recipient your purpose in the very first paragraph. Write it in a conversational and friendly tone. Add some reference to the need for prompt response. Chances are that it will be answered right away or not at all.

Regarding the questions, there are a few basic concepts that should be followed:

- Avoid ambiguity. For example, the question, "Where were you born?" could be answered in a number of ways — "at home," "in France," etc. However, the question, "In what city were you born?" will elicit a specific response.

- Start with general, screening-type questions before proceeding to specifics. If you want response only from married men, don't wait till you're halfway through the questionnaire before asking if the respondent is male and married.
- Leave ample room for reply, but remember that the results will have to be tabulated eventually so "yes/no" answers make this task much easier.
- Questions concerning personal habits or problems are best avoided unless the information is absolutely essential to the success of the survey. The same question that might be answered in an interview will be rejected in a questionnaire and may even result in the form being thrown away.
- Test the questionnaire on several persons before having it printed.
- It will take several drafts before you arrive at an acceptable questionnaire. Edit, evaluate, ask for others' opinions and edit some more. An effective survey instrument requires your best effort. If you are unwilling to make the effort, turn it over to a consultant or scrap the project.
- Always keep in mind the fact that the information gained from the survey will have to be put in some form of table or graph that can be used for comparison and correlation.

When the market data are assembled from all possible sources, it is time for analysis and the setting of goals. The analyzing of information almost always produces a number of results that merely reinforce positions that have previously been taken. It is useful to have documentation that makes decisionmaking more comfortable.

The process of analysis should ideally be an ongoing effort. If the information is entered and stored in a computer, it can be updated and retrieved for future study much more easily.

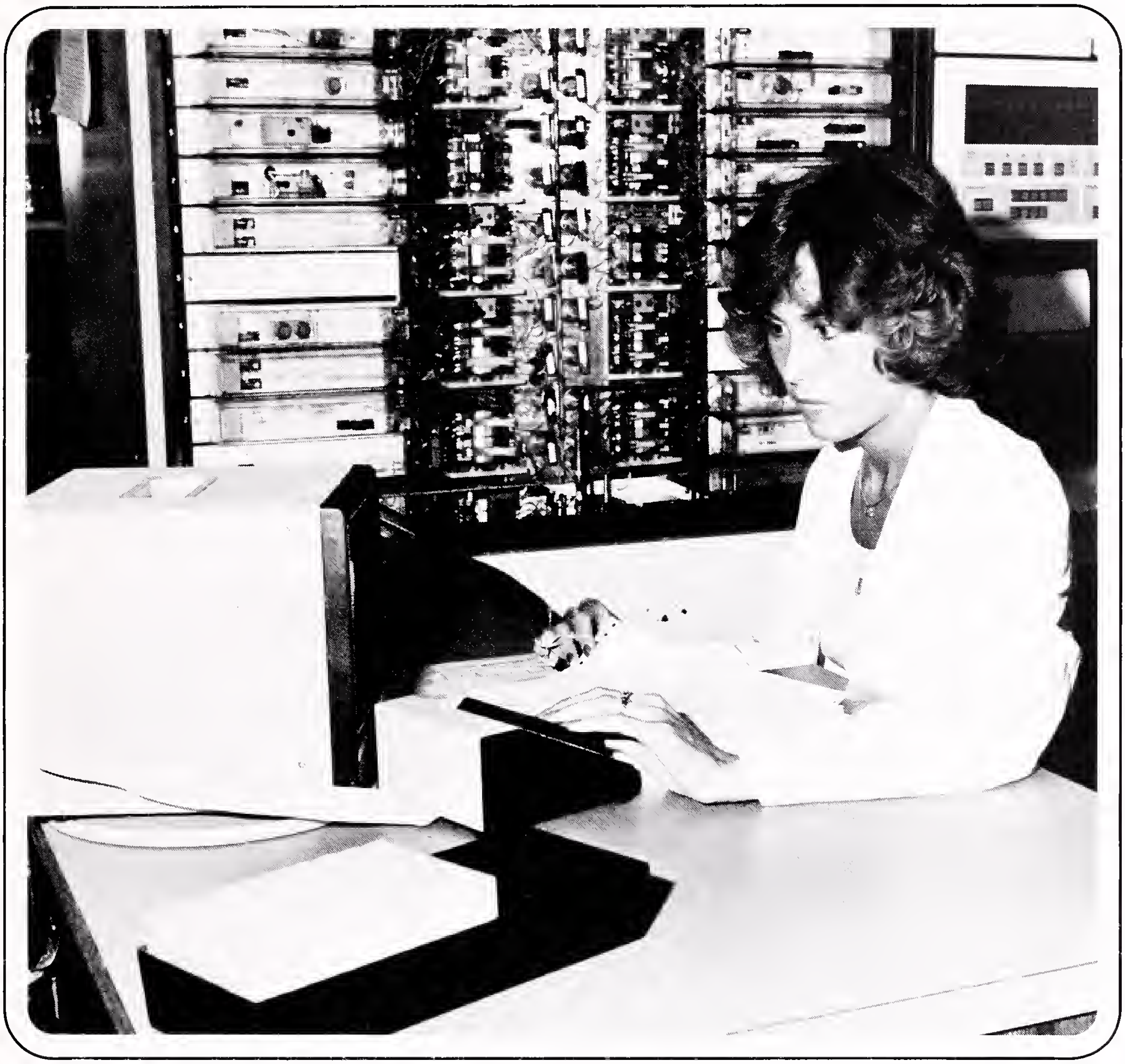
Once you have determined that the market situation is favorable to pursuing your primary objective, it is necessary to develop an action plan, or hierarchy, that will result in accomplishing the objective. The first step in this process is to clearly and definitively write out the primary objective. At this point, it should be shared with office staff, partners and others who must have a role in reaching the objective.

Then a series of sub-objectives should be defined and prioritized with a time-line and a responsible person assigned to each. If, for example, it is decided that x-ray services will be offered by the practice, the primary objective might be stated, "The practice will purchase x-ray equipment, hire necessary technologists and install the system within 120 days." Obviously, the list of sub-objectives would include such items as:

1. Contact x-ray equipment suppliers and arrange for a representative to inspect office site and develop proposal for installation: Dr. Smith (complete by X — 100)
2. Have building contractor inspect site and develop renovation proposal: Dr. Edwards (complete by X — 110)
3. Prepare position description, establish wage scale, place classified ad and begin recruitment of x-ray technologist (complete by X — 115)
4. Interview and select x-ray technologist: Drs. Smith and Edwards (complete by X — 45)
5. Etc., etc. until all steps have been described, assigned and given a time-line for completion.

This process will provide a methodical and soundly-based means of developing and accomplishing marketing objectives which will keep your practice flourishing in the coming years.

This article is a sample selection from the developing MSMS manual, "Meeting the Challenge of the 80's," which will be available to MSMS members in January. Major sections of the manual will deal with practice management, communications, ethics and competition. The manual is the project of the MSMS Committee on Public Service, chaired by Robert D. Burton, MD, Grand Rapids. Excerpts will appear in Michigan Medicine *throughout 1982. They are designed to be removed from the magazine and saved for reference until the entire manual is available.*



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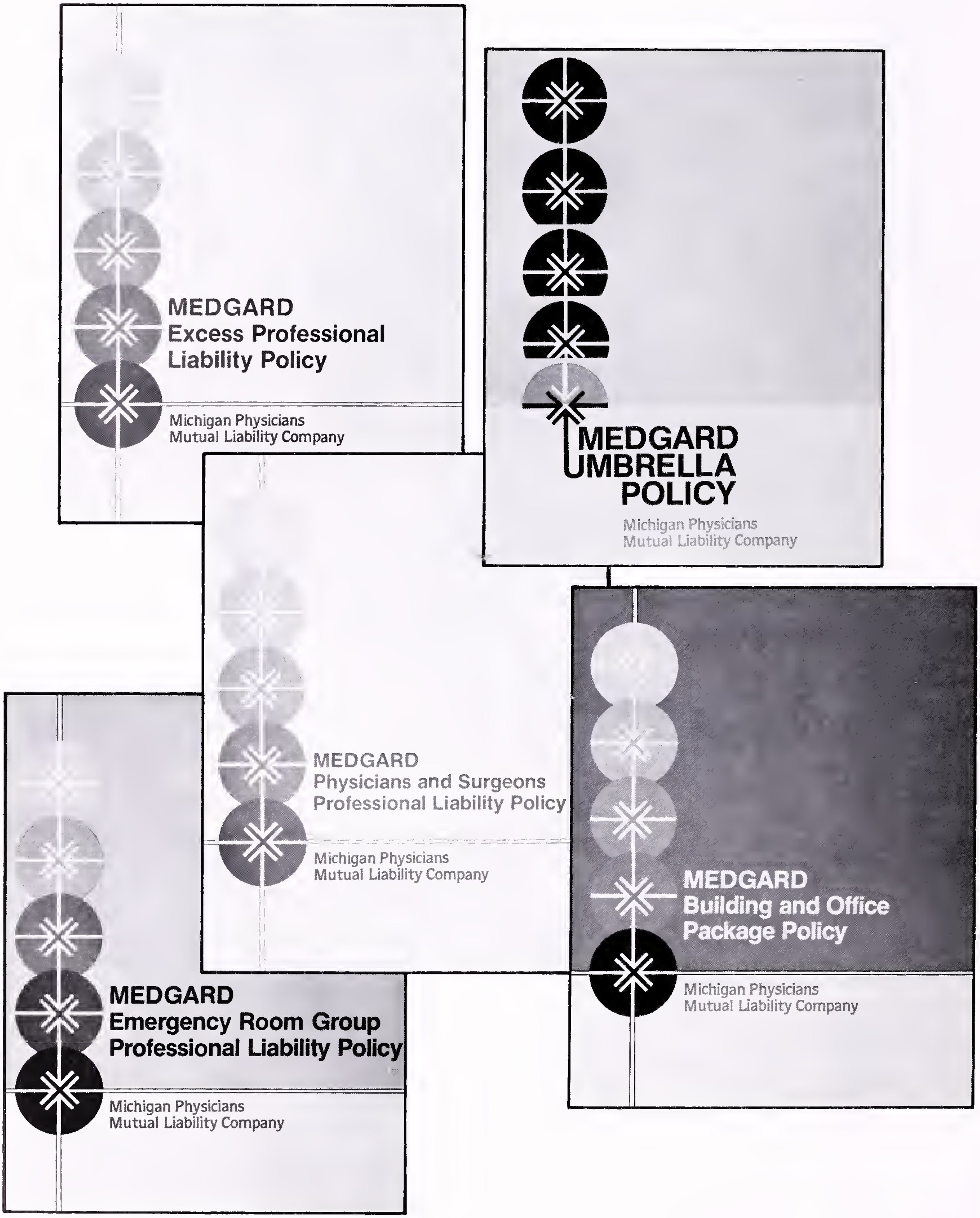

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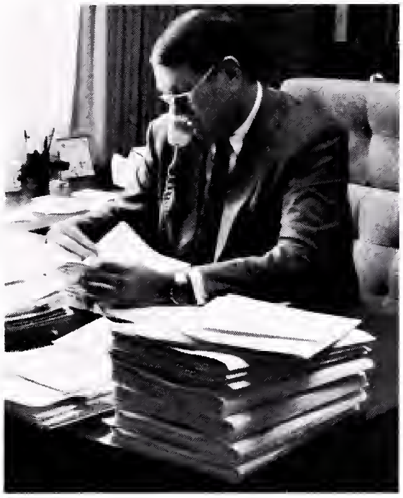

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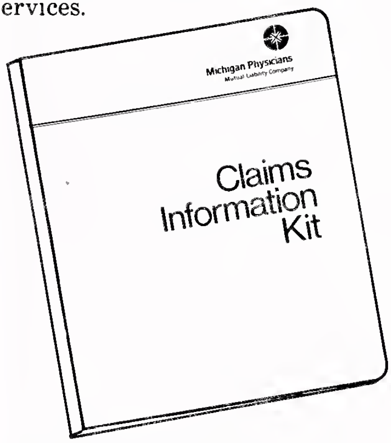

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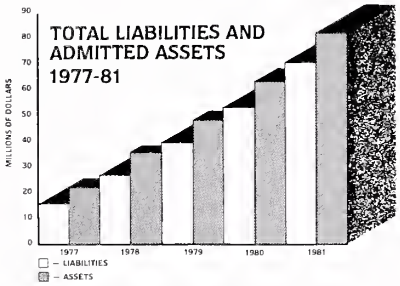

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VIEWS

What makes the Blues tick?

By Rhoda Powsner, MD, JD
Ann Arbor

What makes those @ #$*&! Blues act the way they do?

That's a question more than one Michigan physician has asked in recent years. This article is an outgrowth of a "backgrounder" presentation the author made to the MSMS Council at its regular meeting Sept. 8 in East Lansing. The reasons for BCBSM actions were put so well at that session and received so well by MSMS councilors that *Michigan Medicine* requested Doctor Powsner to make her observations available to all MSMS members through the magazine.

Blue Cross and Blue Shield were created during the Depression by hospitals and physicians, with the assistance of state legislatures.

Their goal was to make affordable health care accessible to the population, and to provide revenue to the hospital and medical communities by allowing subscribers to pre-pay for guaranteed services if and when a need for medical care should arise.

In Michigan, the medical service corporation (Blue Shield) and the hospital service corporation (Blue Cross) were created under enabling acts 1939 PA 108 and 109 respectively. Enabling legislation was deemed necessary to define the non-profit pre-payment plans' legal status, distinguishing pre-payment for health care services from insurance.

Pre-payment hospital service plans were fostered by the American Hospital Association (AHA). Spurred on by authentic Blue Cross pioneers such as Rufus Rorem and John Mannix, the AHA had by the mid 1930s become the base for the fledgling Blue Cross movement. The AHA devised standards for Blue Cross plans and became custodian of the emblem, which consisted of a blue cross imprinted with the AHA seal. Only pre-paid hospital service plans which conformed to AHA standards were permitted to use the emblem. In his capacity as director of the Commission on Hospital Service for the AHA, Rorem toured the country promoting the formation of hospital service corporations under enabling legislation such as Michigan's.

Doctor Powsner is a cardiovascular surgeon, a lawyer and a member of the MSMS Ad Hoc Task Force on Rate Regulation. She also serves on the MSMS Task Force on Professional Liability.

The Detroit District Hospital Council and the Michigan Hospital Association founded Michigan Blue Cross, as the "agent" of the hospitals. Based on the experience in Minnesota and Ohio, where the agency relationship exempted hospital service pre-payment plans from the laws governing insurance, the incorporators of Michigan Blue Cross did not believe that enabling legislation was necessary. However, Michigan State Medical Society's sponsorship of enabling legislation for its medical service plan, plus the recognition that pre-paid service plans were a new phenomenon, tipped the balance, and the hospitals supported passage of PA 109. Even so, the president of the Michigan Hospital Service made it clear that he considered the act regulatory and not necessary for the legal existence of the plan as constituted.

". . . Michigan Blue Cross . . . was incorporated as the 'agent' of the hospitals; the $10,000 required to begin operation was supplied by Henry Ford, Grace and Harper hospitals."

To promote the stated goal of the legislation — that is, to bring affordable health care to the people, the legislature granted the plans special tax treatment and imposed less onerous reserve requirements than those required of commercial, for-profit insurance companies. In addition, PA 109 permitted Blue Cross to enter into contracts with participating hospitals, a unique arrangement which has allowed Blue Cross a distinct advantage over commercial health insurers as the Blue Cross market share has increased.

The State's imprimatur gave the plans legitimacy. Regulation of reserves, and, in the case of the hospital service corporations, the insurance commissioner's review of subscriber premiums as well as hospital reimbursements, were seen as assuring the public protection from fraud.

Michigan Blue Cross' growth over its first decade was phenomenal. But with the increase in enrollment and continued liberalization of benefits, its financial status became precarious despite premium increases. The hospitals, which had initially been reimbursed on a flat per diem basis, demanded a readjustment of the reimbursement schedule to meet the rapidly rising costs of the hospital industry. The 1946 departicipation of the 14 Sisters of Mercy hospitals resulted in a crisis which saw the insurance commissioner suspend the sale of new subscriber policies and saw Blue Cross refine it's system of hospital reimbursement.

Blue Cross and the hospitals drew closer together as a result of this episode. Blue Cross had learned it must be responsive if it were to retain hospital participation. The new hospital reimbursement formula was based on individual hospital costs plus two percent.

By the mid 1950s, Blue Cross premium rates were rising so rapidly that subscribers demanded intervention by the insurance commissioner. Rate-hearings were used as a device to defuse the public outcry. But the basic fact was that Blue Cross was too dependent on the hospitals to negotiate reimbursement so as to hold down costs effectively, and too dependent on subscribers to cut back benefits as it fought for economic survival. Blue Cross was also faced with competition from the commercial health insurers who had aggressively entered the field.

The mid 60s saw a worsening of the problems. Medicare and

continued on page 640

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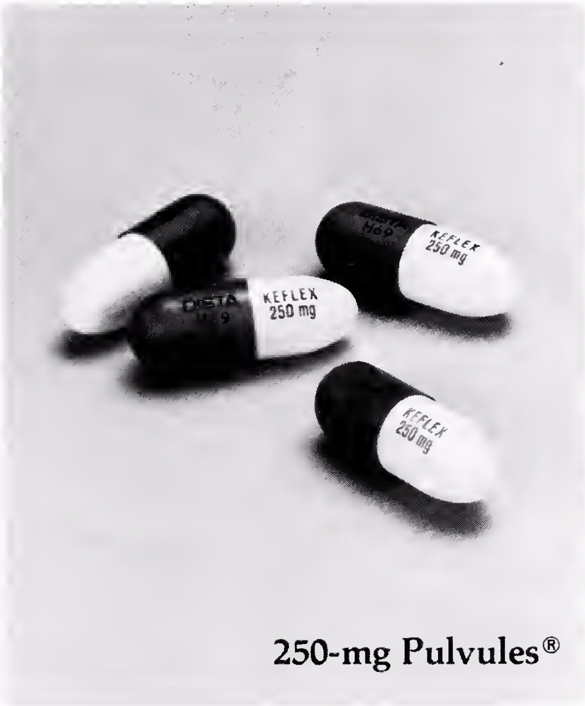

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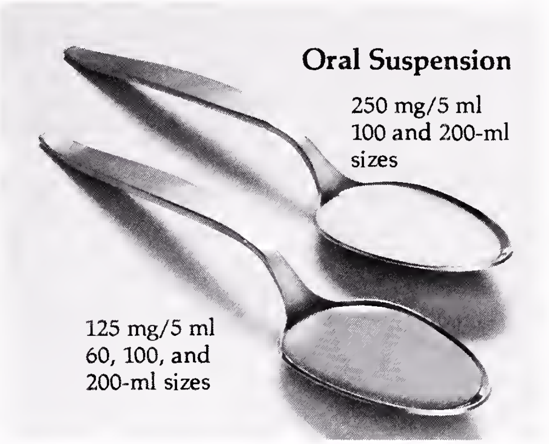

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Medicaid were enacted in 1965. Comprehensive health planning and certificate-of-need legislation were passed, leading to the formation of a cost-enhancing, quality-maintaining hospital industry cartel, especially in the highly industrial areas. With the increasing use of more sophisticated technology and therefore an emphasis on larger tertiary facilities, hospital costs and health care premiums continued to rise.

By 1982 the problem presented by increasing costs seemed almost insurmountable. Pre-paid hospitals and medical service plans, which had been created to bring affordable health care to the people, claimed they could no longer accommodate non-group subscribers, group converters, and elderly Medicare subscribers at prices considered "reasonable" or "affordable."

BCBSM has a dominant market share in this state: 72 percent of the physicians are participating providers: all but two short term acute care hospitals in the state participate. In many respects BCBSM reimbursement practices control the manner and substance of medical practice in Michigan. If it cannot use its market power to protect its subscribers as it is now functioning under the 1939 enabling act, a change is indicated.

The current economic recession and the Blue Cross Blue Shield of Michigan (BCBSM)* court challenge to its new enabling legislation, 1980 PA 350, have emphasized many of the problems of the pre-payment plans under the 1939 enabling act. In 1962 Walter McNerney suggested in *Hospital and Medical Economics*, a comprehensive study of hospital and medical pre-paid plans in Michigan undertaken at another time of great concern over rising costs, that most of the problems faced by Blue Cross have resulted from the inherent tension between the two roles it plays; as *agent* of the hospitals, as stated in its Articles of Incorporation, on the one hand; and as the *provider* of services to the subscribers on the other.

The tension to which McNerney alluded is not based solely on a perceived need of Blue Cross to protect the hospitals, but is also the result of the fact that Blue Cross serves two demanding masters: the hospitals, with which Blue Cross is philosophically aligned; and the subscribers, the majority of whom in Michigan have been unionized employees of the auto industry.

BCBSM walks a financial tightrope attempting to reimburse hospitals at "acceptable" levels while fulfilling the service commitments which emanate from collective bargaining agreements.

Disclaiming what has appeared at times to be Blue Cross' dominant purpose, i.e., the preservation of the voluntary hospital sector. A. Douglas Coleman, upon receiving the AHA's 1965 Justin Kimball Award, remarked that it was imperative that he put to rest the canard that Blue Cross was formed to preserve the voluntary hospitals. It was Coleman's belief that support of prepayment by the hospital sector under the circumstances was an indication of it's commitment to the public's need.

". . . most of the problems faced by Blue Cross have resulted from the inherent tension between the two roles it plays: as agent of the hospitals . . . and the provider of services to the subscribers . . ."

Offering a somewhat different view from McNerney of the significance of Blue Cross' role as agent for the hospitals, Rufus Rorem described the origin of the agency relationship as the means whereby early plans in Minnesota and Ohio could avoid stringent reserve and other requirements placed on commercial insurers. Custom, therefore, and not a well-thought-out agent/principal relationship, may have dictated the wording of Michigan Blue Cross' Articles of Incorporation.

In any event, today BCBSM is so anxious to preserve hospital participation that its attempts at cost containment are invariably less than serious. Even with prospective reimbursement, caps can be exceeded upon "justification."

Although BCBSM audits hospital utilization, this utilization review does not deal with medical necessity; rather, it deals with performance of service in compliance with contract benefits, a "cost containment" mechanism designed to maximize the appearance of good business practice.

Blue Cross officials blame increases in utilization largely on physicians. As provision of services increased 13.4 percent in 1981 while the fee increase to physicians across the state was held to 4.7 percent. Additionally, these same officials have articulated the view that quality of medical care can't be meaningfully measured, thereby implying that not much can be done to correct overutilization.

But when concurrent review of medical practice is undertaken, usually under contract with PSROs, Blue Cross will not deny benefits for medically inappropriate care if the attending physician does not agree with the PSRO assessment. Unless meaningful review is undertaken and sanctions such as those employed by Medicare are invoked, it is virtually impossible to modify unsatisfactory physician behavior. In view of Blue Cross' attitude that physicians are primarily responsible for the difficulty in containing cost, it would seem axiomatic that definitive action of this sort be taken.

BCBSM reimburses non-institutional providers (allopaths, osteopaths, podiatrists, etc.) on the basis of a complex formula related to charges for services. Reimbursement to these non-institutional providers has been held virtually constant for the past four years in southeastern Michigan. However, during that same four year period hospitals in southeastern Michigan have continued to receive increases in reimbursement on the order of nine to 10 percent per year.

Obviously BCBSM is at the crossroads. Whether or not PA 350 survives BCBSM's court challenge, the problems which exist will not disappear without an extensive overhauling of priorities and practices. BCBSM will have to compete cost-effectively in the marketplace of the 1980s or bow to other insurers or solutions which can meet the needs of the time.

References are available from the author.

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*Blue Cross and Blue Shield merged in 1975.

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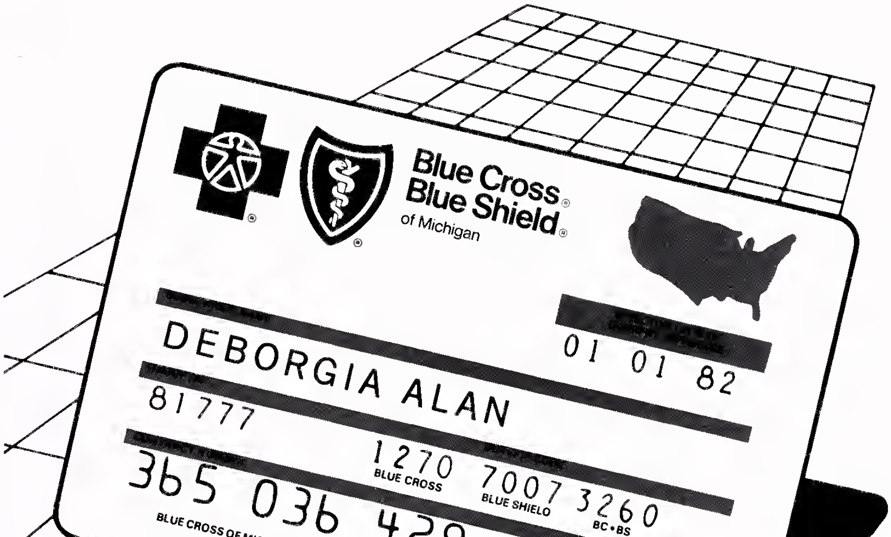
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AMPAC, MDPAC the means for MDs' political involvement

By Thomas R. Berglund, MD
Portage

For those of us who have been AMPAC members for a long time it's a good idea to step back occasionally and remind ourselves just what the AMA intended with the formation of its political action committee. We might also provide other physicians with some valuable insight into the AMPAC purpose at the same time.

In 1961, the AMA House of Delegates realized that the Association's lobbying efforts were not what they could be, due to lack of adequate physician involvement in the political process. They therefore resolved to create an American Medical Association Political Action Committee.

AMA link

At that time, a nonprofit organization could not legally be involved in political fundraising; AMPAC was therefore established as a separate organization. The AMA Board of Trustees maintained a link by appointing the members of the AMPAC Board of Directors and funding administrative operations through yearly grants.

Subsequently, each of the state medical organizations formed state PACs. These PACs jointly raised funds with and participated in educational forums sponsored by AMPAC. AMPAC field staff visited the state medical societies to assist PAC staff. At the same time, contributions to candidates were made by AMPAC and the state PACs.

Year by year, AMPAC and the state PACs grew to become the largest non-labor PAC in the country. AMPAC was innovative from its inception, conducting continuous research on the American political process.

In 1971, the U.S. Congress passed the Federal Election Law (amendments followed in 1974 and 1976), greatly expanding the scope and recognition of PACs. Today we have over 3,000 such groups, many of them small. The legislation also addressed the reporting of contributions and set a limit of $5,000 per candidate per stage of election cycle (primary, general, runoff if necessary).

In 1976, Common Cause brought suit against AMPAC and many state medical PACs — charging that, in the aggregate, they exceeded the $5,000 limit per candidate. Three years of legal battles followed. Finally, in 1979, AMPAC signed a conciliation agreement in which it admitted no guilt, paid no fine, protected all candidates who had received funds, and agreed that AMPAC and state PACs were "connected with" each other. In doing so, AMPAC agreed that the groups would not exceed $5,000 per candidate in the aggregate per stage of election in the future.

In 1980, AMA made AMPAC a part of its Public Affairs Group, with political funds as a separate, segregated fund of AMPAC as provided for in the Federal Election Law. The change was accomplished in 1980, and AMPAC moved to Washington the following year.

In April of 1982 AMPAC moved into the newly completed Washington AMA Building. The AMA Washington staff is on the eleventh floor, while AMPAC occupies the twelfth. Staff changes concurrent with the move to Washington included the appointment of Peter Lauer as executive director of the Division of Political Education; Jack Hotaling as assistant director; and Diane Waltman as director of the Department of Political Education. In addition, three new regional political directors were hired.

AMPAC is now firmly situated in the nation's capital, working within the AMA structure to elect friends of American medicine to Congress. It continues to lead the way among PAC's with such innovative strategies as benchmark surveys for candidates, positive independent expenditure programs (direct mail campaigns, TV ads, "drive time" commercials) and other techniques.

AMPAC, which is bipartisan, supports friendly incumbents and challengers. Its honest and straightforward approach has put the American Medical Association in the forefront of the political action movement.

Takes money

Of course, all this takes money. In this election cycle alone, AMPAC will spend about $2.6 million on direct candidate support, independent expenditures, and surveys. Twice that amount could easily be utilized.

One way that you can help is to become a sustaining member; in Michigan, for example, this involves only $150 (less than $3 a week), and enables you to support friendly legislators throughout Michigan and the nation.

Do you want to make a difference? If I may repeat the words of Congressman Newt Gingrich from Georgia at our September workshop in Washington:

> "If you can look in the mirror in the morning and be content that you contributed nothing to help keep this country free for your children and grandchildren, then fine — I have nothing to say to you."

You *can* do something. Please send your personal (not corporate) check for $150 today to MDPAC, P.O. Box 769, East Lansing, 48823. Support those who support medicine.

Doctor Berglund is former chairman of The Michigan Doctors Political Action Committee and currently is the only Michigan member of the American Medical Political Action Committee board of directors.

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Aside from enabling patients to fall asleep more quickly and sleep longer, Dalmane seldom causes morning hangover. Most Dalmane patients feel alert and refreshed when they awaken. In 53 paired-night clinical studies comparing Dalmane and placebo in 2010 insomniac patients with a variety of secondary diagnoses, most Dalmane patients awakened more alert and refreshed, and less groggy and drowsy, than on nights when they had taken only placebo.[1] In a double-blind crossover study of 42 patients in private practice, approximately three times as many patients reported feeling refreshed and alert upon awakening after a night on Dalmane (flurazepam/Roche) compared to placebo nights.[2] This difference was highly significant ($p<0.001$). And a retrospective study of 2542 hospitalized patients who received Dalmane revealed only a 3.1% incidence of side effects.[3]

While residual effects from Dalmane therapy are infrequent, patients should be cautioned about drinking alcohol, driving or operating hazardous machinery after ingesting the drug.

Efficacy and safety in a broad range of patient types.

Over 2000 clinical trials involving more than 10,000 patients have shown that Dalmane patients fall asleep sooner, sleep longer and experience fewer nocturnal awakenings.[4] The safety and efficacy of Dalmane have been demonstrated in medical and surgical hospitalized patients, in patients seen in office practice and in elderly patients.[5-8] Since the risk of oversedation, dizziness, confu-

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Contemporary Hypnotic Therapy '82

sion and/or ataxia increases with larger doses in the elderly, it is recommended that the dosage be limited to 15 mg.

Moreover, the efficacy and safety of Dalmane for the treatment of insomnia have been demonstrated in thousands of patients with a variety of primary medical conditions, including cardiovascular, neuropsychiatric, endocrine-metabolic, gastrointestinal, genitourinary, respiratory and musculoskeletal disorders.[1] Dalmane (flurazepam HCl/Roche) is contraindicated in pregnancy and in patients hypersensitive to the drug.

Avoids rebound insomnia upon discontinuation.

Rebound insomnia—a worsening of sleep beyond pretherapy levels after drug discontinuation—has been reported as a potential clinical problem with some hypnotics.[9,10] However, this problem has not been reported with Dalmane. In eight out of eight sleep laboratory studies, there were no reports of rebound insomnia.[11] When you prescribe Dalmane, you can be confident of efficacy that enhances therapeutic progress. Your insomniac patients can be assured of a restful night, night after night—a good start for a good morning.

References: **1.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **3.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **4.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **5.** Meyer JA, Kurland KZ: *Milit Med 138*:471-474, Aug 1973. **6.** Feffer HL, Gibbons B: *Med Times 101*(8):130-135, Aug 1973. **7.** Jacobson A *et al: Psychophysiology 7*:345, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 1978. **10.** Kales A *et al: JAMA 241*:1692-1695, Apr 1979. **11.** Monti JM: *Methods Find Exp Clin Pharmacol 3*(5):303-326, 1981.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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NEWS

By Sheri W. Greenhoe
East Lansing

Doctor Vaitkevicius

Doctor Friedlaender

Internationally respected internist, oncologist and cancer researcher **Vainutis K. Vaitkevicius, MD,** has been appointed to a three-fold position as chairman of the Department of Internal Medicine at WSU School of Medicine, chief of medicine at Harper-Grace Hospitals, and the first physician-in-chief of the departments of medicine in the Detroit Medical Center. His appointment follows a year-long national search to find a replacement for **Arnold Weissler, MD,** who stepped down as chairman of internal medicine last summer . . New editor of *Immunology & Allergy Practice*, the scientific journal of the American Association for Clinical Immunology and Allergy is **Sidney Friedlaender, MD,** Southfield. Doctor Friedlaender, who also is president-elect of the association, is in charge of all editorial content of the journal which goes to more than 16,000 physicians in the US, Canada, Mexico and overseas. . . Six new associate and assistant deans have been appointed at the U-M Medical School. They are: **Robert E. Reed, MD,** senior associate dean; **Richard L. Tannen, MD,** associate dean for hospital affairs; **John E. Niederhuber, MD,** associate dean for research; **Henry H. Swain, MD,** assistant dean for faculty affairs; **Peter M. Burkholder, MD,** professor of pathology and assistant dean, and **Margaret J. Hunter, PhD,** assistant dean for admissions. . . . **Michael I. Salib, MD,** head of Henry Ford Hospital's Division of Executive Medicine, is the new chairman of the HFH Medical Board. The board is an elective body representing the entire HFH staff, including 400 senior staff physicians and surgeons. . .. U-M professor emeritus of neuroanatomy, **Elizabeth C. Crosby, PhD,** was honored at ceremonies recently when the U-M Section on Neurosurgery dedicated its research laboratories in her name. The dedication was "an official acknowledgement by the department . . . of her great contributions now and over the past several decades." Doctor Crosby is 93. . . . **Lowell E. Blanchard, MD,** Hudson, was honored at a community open house recently which commemorated his 50 years of dedicated medical practice in that area. The event was sponsored by Thorn Hospital staff. . . . **Boy Frame, MD,** is in charge of planning the Henry Ford Hospital Division of Bone and Mineral Metabolism's second international specialty symposium. The May event is expected to bring more than 500 researchers and practitioners from throughout the world for an exchange of clinical and investigative material. Doctor Frame also has been appointed consultant editor of the *American Journal of Medicine*. . . . **Robert A. Norum, MD,** Henry Ford Hospital Department of Internal Medicine, has been awarded a $200,000 three-year grant by the NIH to study familial breast cancer. **Fred W. Hetzel, MD,** of the HFH Department of Therapeutic Radiology, has been awarded a grant for $159,000 from the National Cancer Institute. He will study a tumor model test system. . . . **Marjorie Peebles-Meyers, MD,** physician-in-charge of the medical unit at Ford Motor Company World Headquarters and Ford Motor Credit Company, was honored recently for her many years of dedicated medical service to Detroit. She was presented the Mercy Medallion by Mercy College, an award given to individuals whose lives and activities are examples of works of mercy. Other awardees were Gov. William Milliken, Joseph L. Hudson, Jr., and Douglas Fraser. . . . **Diana Killip, MD,** of the Henry Ford Hospital Adolescent Medicine Program has been named director for the Detroit component of a nationwide $12 million project to consolidate medical services for high-risk teenagers and young adults. . . . **Joseph C. Cerny, MD,** has been installed as president of the Michigan Branch of the American Urological Association and appointed to the Examination Committee of the American Board of Urology. . . . **Angelous A. Kambouris, MD,** is the new president-elect of the Detroit Academy of Surgery. . . . Recipient of the Frederick A. Coller Traveling Fellowship Award is **Robert E. Lee, MD,** Detroit. The award recognizes the excellence of a paper Doctor Lee presented to the Michigan Chapter of the American College of Surgeons. . . . **Nathan Levin, MD,** Detroit, has been elected to the executive committee of the Medical Advisory Board of the National Kidney Foundation, and to the Board of Directors of the Renal Physicians Association. Doctor Levin is head of the Henry Ford Hospital Division of Nephrology and Hypertension. . . . New chairman-elect of the environmental section of the American Public Health Association is **Donald R. Brown, PhD,** director of the U-M Hospitals' department of environmental health and safety. Doctor Brown recently presented a paper at the Fourth National Conference of Sterilization and Disinfection in Bologna, Italy. . . . **Frederick W. Hyde, Jr., MD,** Lathrup Village, was honored recently for 35 years of service to Grace Hospital at a banquet at the Westin Hotel. Doctor Hyde, former vice president of Harper-Grace Hospitals, was very much involved in the development of the Detroit Medical Center and Grace Hospital's decision to remain in Detroit rather than move to the suburbs. . . . New vice president of the Inter-American Zone of the World Organization for Digestive Endoscopy is **Bernard M. Schuman, MD,** Detroit. He will be responsible for coordinating the activities of the national endoscopic societies in Canada, the US, Central and South America. . . . Recipient of the "Heart of Troy" award is **Tai P. Yoo, MD,** head of psychiatric services for Henry Ford Hospital's Northeast Facilities. The annual award recognizes "outstanding contributions to and close work with the Troy community."

Ms. Greenhoe is editorial secretary to *Michigan Medicine*.

DEFLATION

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Your telephone manner can put you at risk, Doctor

By K. L. Christenson, MD
Detroit

The following article was excerpted from the prize-winning manuscript in the 1982 Robert E. Rice, MD, Risk Management Awards Program, sponsored by Michigan Physicians Mutual Liability Company. The author, K. L. Christenson, MD, Detroit, received $1,000 as the recipient of the first place award, which was granted by a panel of physician judges who are members of the MPMLC Risk Management Committee.

The competition is named for the late Robert E. Rice, MD, an incorporator of MPMLC, and an original member of the Risk Management Committee. All allopathic and osteopathic physicians-in-training are eligible to compete for the annual award. Contact MPMLC for details on the 1982-83 competition.

In the United States, use of the telephone is a significant part of medical practice. It is a time-saver, step-saver, and money-saver. Those who have been without it even for a short time will readily attest to its usefulness and convenience.

Because of its importance in the practice of medicine, the telephone can be the source of malpractice risks in several ways. An awareness of the risks would seem to be the greatest benefit to the physician in dealing with them and avoiding them.

Doctor Christenson is a family practice resident at Saint John Hospital in Detroit. Bibliography available from the author upon request.

Physicians diagnose and treat illness over the telephone, they prescribe medication by telephone, they give orders for hospitalized patients over the telephone, they give and receive lab results over the telephone, and they use the telephone simply to keep their offices full of scheduled patients. It is no wonder that malpractice cases arising from medical practice over the telephone are not rare.

Some have thought that because a physician does not actually see the patient during a telephone call that the physician is somehow free of responsibility. This is false — the very act of giving medical advice to a patient by telephone creates a doctor-patient relationship and makes the physician legally responsible for the outcome.

Telephone diagnosis

Obviously the physician is at a disadvantage in making a diagnosis without the benefit of the auditory, visual, tactile, and olfactory senses. Also, the physician must do without non-verbal communication that is possible with face-to-face contact. Logically, with these disadvantages, the possibility of misdiagnosis and mistreatment and eventual malpractice litigation are greater. It is wise to give patients the benefit of any doubt — to error on the side of requesting to examine the patient rather than relying solely on the telephone.

Lack of documention

Typically, when a patient is seen personally by a physician in his office there is a written or dictated record of the subjective and objective information as well as the advice and treatment. However, telephone interaction may not be recorded. Should a question of malpractice be raised, the physician may wish he had a record of what the patient told him and what advice he gave the patient over the telephone.

Second-hand information

When the caller is not the patient himself, especially when the patient is a young child, the physician is receiving second-hand information. It is risky to base advice and treatment on the observations of untrained persons whose judgment may be in error.

Telephone orders

Misunderstood medical orders over the telephone for hospitalized patients can be a liability. They may not be carried out as intended. Also there is the risk of misunderstanding the clinical situation and therefore treating incorrectly.

All telephone orders cannot be avoided: in emergency situations, they are appropriate. However, a hospital record that shows multiple telephone orders given in non-emergency situations may make a jury wonder why the physician could

Continued on page 654

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not see the patient and write orders in person. When telephone orders are necessary, the physician should see the patient as soon as possible and make sure the order was recorded correctly. If it was correct, a note in the progress section should be made stating that it was correct and should be continued. If the order was written incorrectly, it should be clearly stated in the progress record and the correct order written, cancelling the incorrect telephone order.

Telephone prescriptions

Seven to 11 percent of prescriptions issued for adults are telephone prescriptions, as are 10 to 29 percent of those issued for children. According to a study, physicians are prescribing potentially more abusive drugs a greater percentage of the time over the telephone than they are in person. Since a telephone diagnosis is not confirmed in most cases by physical examination and lab tests, telephone prescriptions should be for the safest drug possible. Whenever possible, a non-prescription drug should be recommended. Well known brand names are also advisable because of easier patient recognition and less chance for mix-up.

Lab reports

With the higher volume of lab work done in most hospital laboratories, it is not surprising that a well-meaning lab technician could easily report the wrong lab data. Lab data not only may be reported in error, but also may not get to the correct person. Obviously, either incorrect lab results given over the telephone or failure of the telephone message to get to the right person can lead to incorrect diagnosis and treatment. The physician should use caution when receiving lab reports by telephone — making sure the person giving the report clearly understands the patient's name and hospital or patient number.

Whenever possible, written reports should be requested. In addition, physicians should try to follow-up on all lab tests they order and account for the results of each test. Laboratories should be responsible to send a written report of all lab tests even when the results already have been reported by telephone.

Telephone mechanics

Simple mechanics of the telephone system can produce a malpractice risk in an office setting. The frequency with which patients are greeted with the busy signal when calling to the office is an important factor. It has been reported that the offices' mechanical unresponsiveness is one of the most grating experiences a patient can have — one which can make him feel the doctor is too busy to care. Offices should have adequate telephone lines for in-calling patients. Patients simply may not keep trying to break through the busy signal.

An additional receptionist or separate lines for insurance or other business matters will improve the "office image" and patient satisfaction. It also is suggested that the use of the "hold" button be examined. A caller should never be placed on "hold" before he has had a chance to explain the reason for the call. This is especially applicable when the call is an emergency. No patient should be kept on "hold" for more than one-half minute without the caller being reassured he has not been forgotten.

Telephone calls interrupting the physician while he is examining a patient in his office also can cause problems. The patient may feel that the doctor is too busy to devote a few minutes of individual attention to him and the doctor-patient relationship may be marred. The practice of taking *all* phone calls personally also may cause a backup of patients in the waiting room and irritate those patients as well. During office hours the physician's first responsibility is to the patients who are scheduled for appointments. Only in emergency situations should this not hold true. Physicians can establish a "call back" system to facilitate care of both the scheduled patient and the telephone caller.

Any office procedure that irritates patients and makes them feel neglected or unimportant invites danger of malpractice. This is especially true in cases where the patient is unhappy in the first place with the outcome of medical treatment already received. The irritating telephone system itself can be the "last straw" that brings on a lawsuit.

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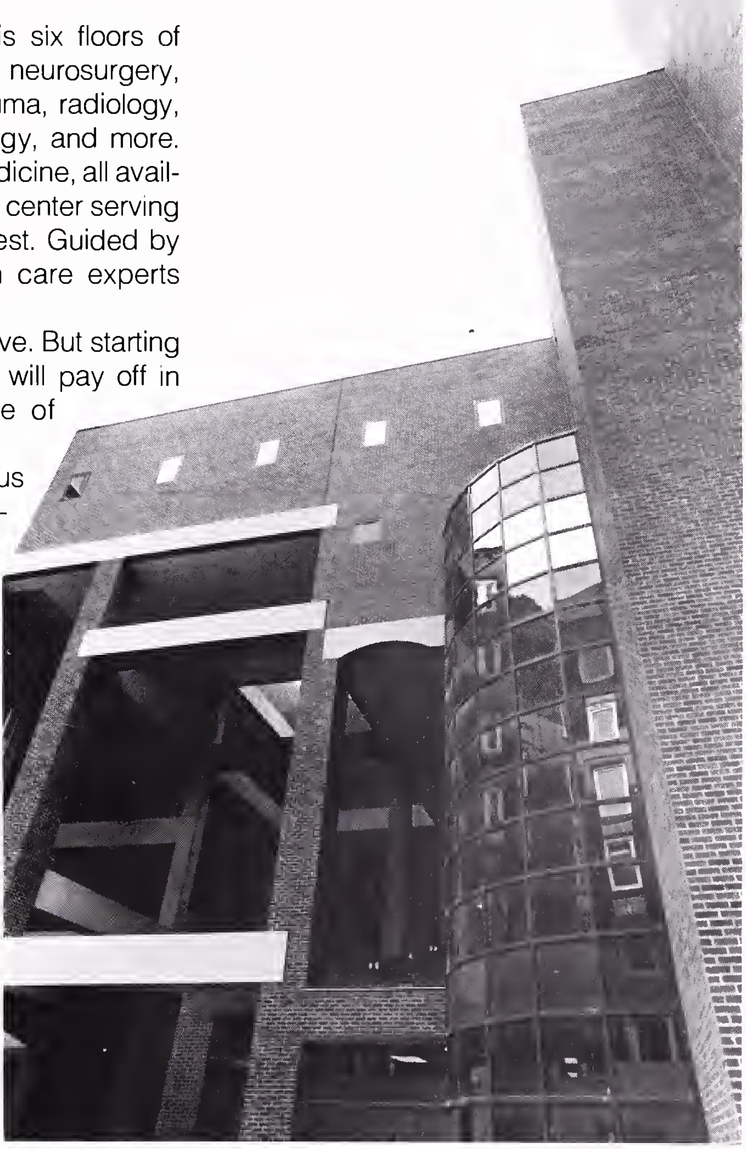

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CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Nov. 18-19-20, Acute Injuries of the Hand: Primary and Definitive Care. Location: Westin Hotel, Detroit. **Sponsor:** WSU School of Medicine Department of Surgery. **Contact:** WSU School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 19 hours of Category I Credit.

Date: Nov. 19-20, Soft Tissue Expansion in Reconstructive Surgery. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education. **Cost:** $350-practicing physicians; $225-physicians-in-training. **Contact:** Office of CME, Dept. of Postgraduate Medicine & Health Professions Education, Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 12 hours of Category I Credit.

Date: Nov. 19-20, Common Surgical Problems in Childhood. Location: Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** U-M Medical School Office of CME, Dept. of Postgraduate Medicine & Health Professions Education and The Surgical Services of Mott Children's Hospital. **Cost:** $155-physicians; $125 physicians-in-training; $125 allied health professionals. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: Nov. 20, Surrogate Mother Symposium. Location: McGregor Memorial Conference Center, Wayne State University, Detroit. **Sponsor:** WSU Schools of Medicine and Law. **For:** OB/GYNs and others interested in fertility issues. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 26-30, Ophthalmology: Basic and Clinical Review. Location: Hyatt Regency Dearborn. **Sponsor:** Kresge Eye Institute, WSU School of Medicine. **For:** Practicing and resident ophthalmologists. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 44 hours of Category I Credit.

Date: Dec. 3, Care of the Burned Patient. Location: Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** Office of CME, Dept. of Postgraduate Medicine & Health Professions Education, the National Institute for Burn Medicine, and The University of Michigan Burn Center. **Cost:** $115 physicians; $85 physicians-in-training and retired physicians; $85 allied health professionals. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 7 hours of Category I Credit.

Date: Dec. 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Dec. 27-31, Clinical Medicine Update II: An Educational Retreat. Location: San Diego. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education. **For:** Clinicians in internal medicine, family practice, general practice, general surgery, pediatrics, and obstetrics and gynecology. **Cost:** $325. **Contact:** Office of CME, Towsley Center for CME, U-M Medical School, Box 057, Ann Arbor 48109 (313) 763-1400. **Approved for:** 18 hours of Category I Credit.

Date: Jan. 22-29, Aspen Conference on Emergencies in Medicine. Location: Aspen Conference Center, Aspen, Colorado. **Sponsor:** WSU Department of Surgery. **Contact:** Theresa Sokol, Department of Surgery, WSU, 6-C University Health Center, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 27.5 hours of Category I Credit.

Date: Feb. 13-19, 1983, Myocardial Infarction and Angina Pectoris. Location: Davos, Switzerland. **Sponsor:** Division of Cardiology of the Hannover Medical School, Hannover, West Germany, and the University of Michigan. **For:** All physicians and surgeons with an interest in ischemic heart disease. **Cost:** $300. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center for CME, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 28 hours of Category I Credit.

Date: Feb. 23-March 1, 1983, Adolescent/Young Adult Medicine. Location: Wailea Beach Hotel, Maui, Hawaii. **Sponsor:** Hurley Medical Center, Department of CME. **Contact:** Hurley Medical Center, Dept. of CME, One Hurley Plaza, Flint 48502, (313) 766-0142. **Approved for:** 20 hours of Category I Credit.

Date: March 9-12, 1983, Neurological Emergencies: A Symptom-Oriented Approach. Location: The Saddlebrook Resort, Tampa, Florida. **Sponsor:** U-M Medical School Office of CME, Department of Postgraduate Medicine and The Section of Emergency Medicine, Department of Surgery. **For (specialty):** Emergency physicians providing emergency care for neurological problems and all health care professionals who encounter emergency situations on a daily basis. **Cost:** $295, $115 for single day attendance. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, Box 057, University of Michigan, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 13.5 hours of Category I Credit.

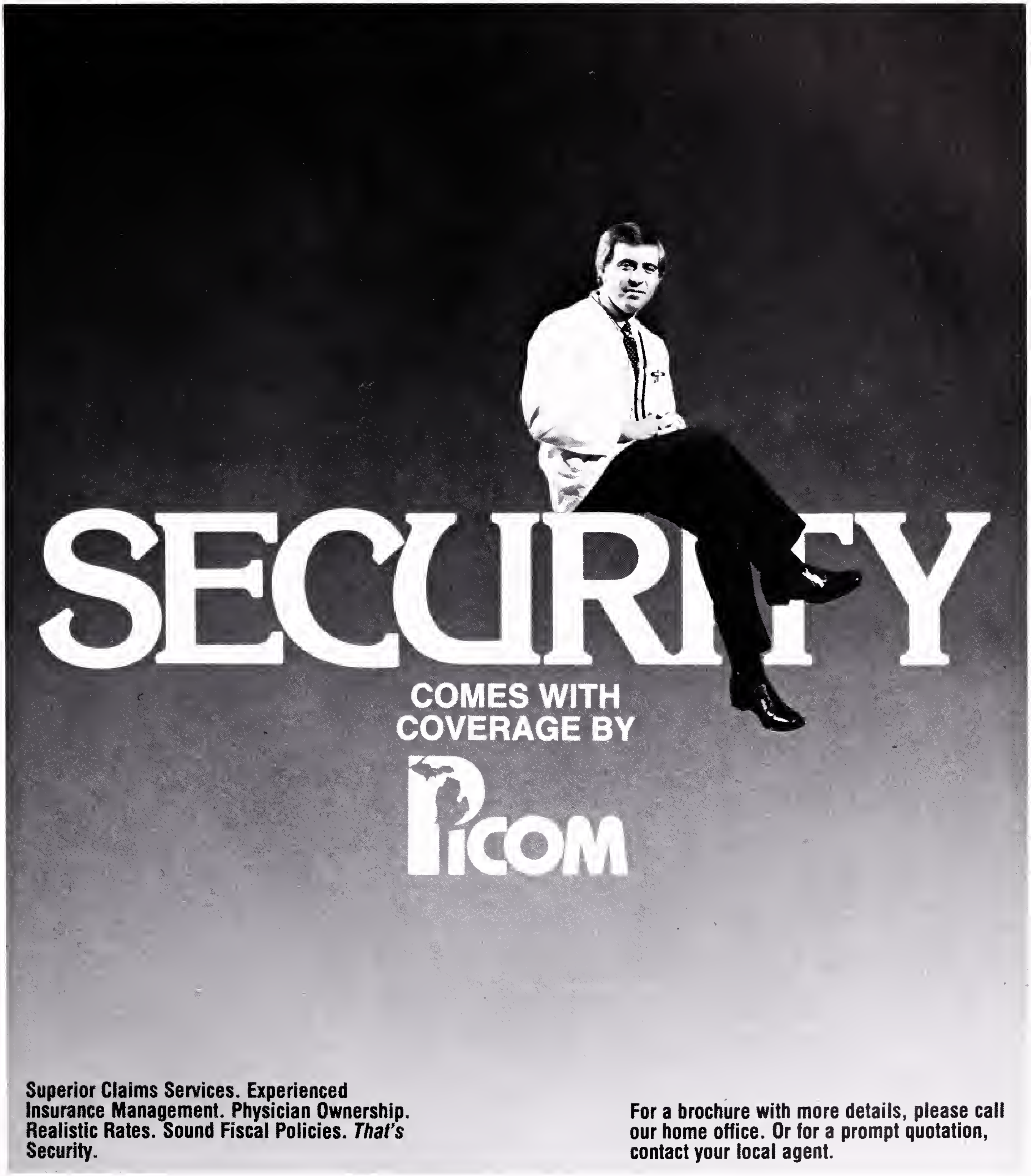
Date: April 8-10, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: June 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Medicine, MSU, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine, Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 21-23, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: Nov. 1-3, 1983, Real-time Ultrasound Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: May 22-24, 1984, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.



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DEATHS

Oscar L. Barland, MD
Thousand Oaks, California

Oscar L. Barland, MD, formerly of Detroit, died August 3. He was 84. Doctor Barland earned his medical degree at Meharry Medical College in Tennessee in 1922. A general practitioner, he was affiliated with Dunbar, Parkside and Mercy Hospitals in Detroit, and was especially interested in meeting the medical needs of the city's low income population. Doctor Barland was active in various voluntary health organizations, and studied roentgenology as an additional interest.

Sanford A. Bennett, MD
Oak Park

Sanford A. Bennett, MD, Oak Park, died August 26 at the age of 72. Doctor Bennett, a retired family practitioner, was a 1937 graduate of Wayne State University School of Medicine. He had been on the staff of Mt. Carmel Mercy, Brent and Northwest Grace hospitals. Doctor Bennett maintained a family practice for 40 years, and had been a member of the American Academy of Family Practice and a past officer in a Detroit Zionist organization. He served as a captain in the US Army Medical Corps during WWII.

Park S. Bradshaw, MD
Sun City, Arizona

Park S. Bradshaw, MD, formerly of Muskegon, died August 17. He was 78. Doctor Bradshaw retired in 1972 from his 36-year pediatrics/allergy practice. He earned his MD in 1930 at the University of Michigan Medical School. He was past president of the West Michigan Pediatric Society, the U-M Pediatric Society, the Muskegon County Medical Society and West Michigan Children's Center.

Harry O. Davidson, MD
Pleasant Ridge

Harry O. Davidson, MD, Pleasant Ridge, died August 20 at the age of 83. Doctor Davidson retired in 1975 after more than 50 years as a Henry Ford Hospital staff member in the Department of Pediatrics. He earned his medical degree in 1923 at the University of Cincinnati. Doctor Davidson was a member of the American Academy of Pediatrics, the Detroit Pediatric Society, and served as a medical officer in the US Army during World War II.

Hypolit K. Filip, Jr., MD
Jackson

Hypolit K. Filip, Jr., MD, Jackson, died August 22. He was 69. Doctor Filip, former chief of staff at Mercy Hospital, retired from his 30-year OB/GYN practice in 1973. He was a 1941 graduate of the University of Michigan Medical School, practiced as a family physician for 15 years, then specialized in obstetrics and gynecology. He had been affiliated with both Mercy and Foote Hospitals in Jackson, and was a former board member of the Jackson Unit of the American Cancer Society. Doctor Filip was one of the founders of the Jackson Pre-Cana Program, a Catholic education program for engaged couples.

John O. Goodsell, MD
Saginaw

John O. Goodsell, MD, Saginaw, died September 11 at the age of 59. Doctor Goodsell, an orthopedic surgeon, was a 1946 graduate of the U-M Medical School. He had been affiliated with Saginaw General Hospital, and was a member of the American Academy of Orthopedic Surgeons and the American College of Surgeons. He had been a captain in the Army Medical Corps during the Korean Conflict, and in 1967 served on the medical ship Hope. Doctor Goodsell was a former president of the Saginaw School Board, and had been a member of the local YMCA board. He was recognized for his work with the American Civil Liberties Union, and was the former president of the Central Michigan Chapter.

Frank B. Heckert, MD
Lansing

Frank B. Heckert, MD, Lansing, died September 21 at the age of 80. Doctor Heckert retired from his 40-year medical practice in 1976. He was a 1931 graduate of Ohio State University Medical School, and served his residency at Case Western Reserve in Cleveland. His postgraduate work was done at the University of Vienna in Austria, and at the University of Berlin in Germany. Doctor Heckert was a senior staff member at Sparrow, St. Lawrence and Ingham Medical Hospitals, and was a life member of the American Academy of Ophthalmology and Otolaryngology. He also was a member of the Pan-American Congress of Ophthalmology.

William A. LeMire, II, MD
Escanaba

William A. LeMire, II, MD, Escanaba, died August 18. He was 74. Doctor LeMire, a lifelong Escanaba resident and patriarch of a family of physicians, was a 1932 graduate of Loyola Stritch School of Medicine. He was a past president of the Delta County Medical Society, and a former MSMS Councilor. For the past 40 years Doctor LeMire, a general practitioner, had been an aviation examiner and a US Public Health Service physician. He was past president of the St. Francis Hospital medical staff, and in 1981 he was honored for 50 years of medical practice by Abbott Laboratories. He was an Air Force flight surgeon in Italy during World War II.

Constantine L.A. Oden, MD
Muskegon

Constantine L.A. Oden, MD, Muskegon, died September 4 at the age of 89. Doctor Oden, a retired surgeon who maintained office hours until shortly before his death, earned his medical degree from New York University College of Medicine. He was a fellow of the American College of Surgeons, and a member of the International College of Surgeons, the American Board of Abdominal Surgeons, the American Proctological Society, and the Michigan Proctological Society. Doctor Oden was an award-winning photographer. He was a Navy surgeon during World War II.

Ernest R. Reinsh, MD
Troy

Ernest R. Reinsh, MD, Troy surgeon, died August 11. He was 82. Doctor Reinsh had been a member of the Providence Hospital staff for 53 years. He earned his MD at the University of Nebraska in 1923, and was a member of the American Society of Abdominal Surgery. In 1973 he received an MSMS 50-year award for medical practice. Doctor Reinsh saw medical military duty in the Navy from 1942 until 1946, and was a member of Phi Beta Pi medical fraternity.

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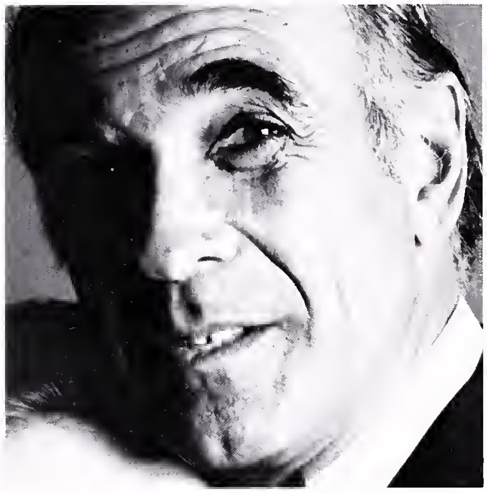

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PRIMARY CARE PHYSICIAN. Prefer board eligible Family Practitioner or Internist. Well equipped community clinic. Requires ability to coordinate medical activities with counseling, nutrition, public health and disease prevention efforts. NHSC assignee preferred. Position requires sensitivity to a struggling economy in a tourist and retirement area. Send resume to Chris Shea, Administrator, East Jordan Family Health Center, 601 Bridge St., PO Box 718, East Jordan, MI 49727 or call (616) 536-2208.

INSTRUCTOR IN INTERNAL MEDICINE WANTED for teaching and instruction of medical students in internal medicine as well as teaching and supervision of resident physicians. Will also do cardiovascular research with emphasis on pharmacological intervention in treating cardiac disease. Requires MD degree, 2 years training in Cardiovascular Fellowship, and 1 year experience. 50 hours per week, $50,000.00 per year. Send resume to 7310 Woodward Avenue, Room 415, Detroit, Michigan 48202. Reference number: 31982.

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DIMENSION III/*Continued*

see more Dimension III cards in the future with deductibles that range anywhere from $100 to $1,500. As health care costs continue to rise, more BCBSM subscribers will be making the change to Dimension III to save premium dollars. Perhaps 1983 is the year that we ourselves should consider a new Dimension in health care.

Available now

Dimension III is available now to unenrolled MSMS members; enrolled members will have the option to change in the near future. Specific open enrollment dates will be announced soon and materials will be sent for review and selection change. January 1, 1983 is the new rate renewal date for all of the BCBSM plans sponsored by MSMS.

Given the present economic environment and the emphasis on cost control, cost-sharing programs will become an even larger portion of the BCBSM health care prepayment business.

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PRESIDENT'S PAGE

New MSMS Dimension III plan gives members co-pay option

By James H. Tisdel, MD
MSMS President

Editor's note: This column is excerpted from an address Doctor Tisdel made recently to members of the Huron County Medical Society. He is making similar statements at other county medical society meetings around the state, as he works to be known as "one of the traveling MSMS presidents."

"Those (?!$%&) health care costs" is a familiar Blue Cross Blue Shield advertisement that many of us can identify with, especially when our own personal health care premiums are due.

Fortunately, last year the MSMS Council elected to offer a new plan which enables the MSMS membership a chance to reduce their health care premiums. The new Dimension III plan (commonly known as comprehensive major medical) is not new to the health care industry; but it is a plan that's less than a year old for BCBSM. Dimension III is a cost-sharing program which requires the subscriber to pay a deductible and coinsurance when benefits are used. Because members share in the expense, program liability is reduced. Thus, BCBSM can offer monthly premiums at a substantially lower rate.

Worth consideration

MSMS first offered the plan to MSMS members and their employees last May. The initial enrollments were less than expected; but as Dimension III is a relatively new BCBSM concept, increased enrollment in the future is anticipated.

Over 60 percent of the MSMS membership is enrolled through the familiar BCBSM Group Plan 94000 with catastrophic master medical coverage. However, as Dimension III premiums are approximately 40 percent less than the 94000 plan, Dimension III is seriously worth consideration.

Dimension III requires the subscriber to first pay a deductible ($500 per individual/$1,000 per family) for all covered services, hospitalization, surgical-medical and broad out-of-pocket expenses not normally covered, such as prosthetic appliances and medical equipment.

Once the deductible amount has been paid, Dimension III pays 80 percent, while the subscriber pays a 20 percent copayment. (For private duty nursing and psychiatric care the payment is 50 percent/50 percent.) When the subscriber's 20 percent copayment equals $1,000, BCBSM pays 100 percent for the balance of the benefit year except for private duty nursing and psychiatric care. A benefit period is a calendar year beginning January 1 and ending December 31.

Dimension III has a per person lifetime maximum of $1 million in benefits.

Along with the deductible and copayment features of Dimension III, there are benefit variances that exist when compared to the familiar 94000 plan.

The significance of these benefit variances of course depends on the health care needs of each individual family. Dimension III is definitely for the individual who desires a streamlined plan and who feels comfortable with the possibility of having to pay some expenses personally.

Streamlined plan

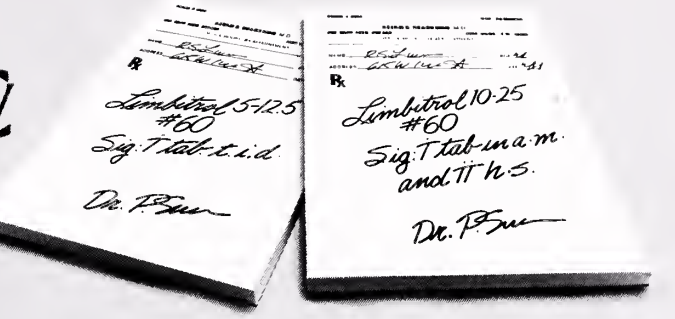
Dimension III is designed as a provider-billed and provider-paid program. Provider billing assures that deductible and copayment amounts from all sources are properly accumulated. All covered Dimension III services provided by participating providers of care are billed directly to BCBSM. BCBSM then subtracts the appropriate deductibles and copayment amounts and pays the provider for any balance. Participating providers may collect reasonable deposits from patients to cover any outstanding amounts or wait to bill for the patient's liability after receiving payment from BCBSM. BCBSM payment for covered services will be in accordance with existing payment and reimbursement policy for each provider type. Charges for covered services not billed by providers are paid by the subscriber who submits a claim form to BCBSM. BCBSM then pays the subscriber directly after subtracting any deductible and copayment amounts owed.

Dimension III uses the recognizable BCBSM identification card with the words "Dimension III" or "Comprehensive Major Medical" printed on the card. We as providers of care can expect to

Continued on page 660

Limbitrol® ⒾⓋ

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline
(as the hydrochloride salt)



In anxious depression,

SPECIFIC FOR THE NONPSYCHOTIC PATIENT

Fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician[1] found a correlation of 0.7 in anxiety and depression scores; another[2] has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

More appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression that contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.[2,3]

Avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and other extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970. **2.** Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* edited by Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **3.** Baldessarini RJ, Tarsy D: Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress,* edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p. 999.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

> ***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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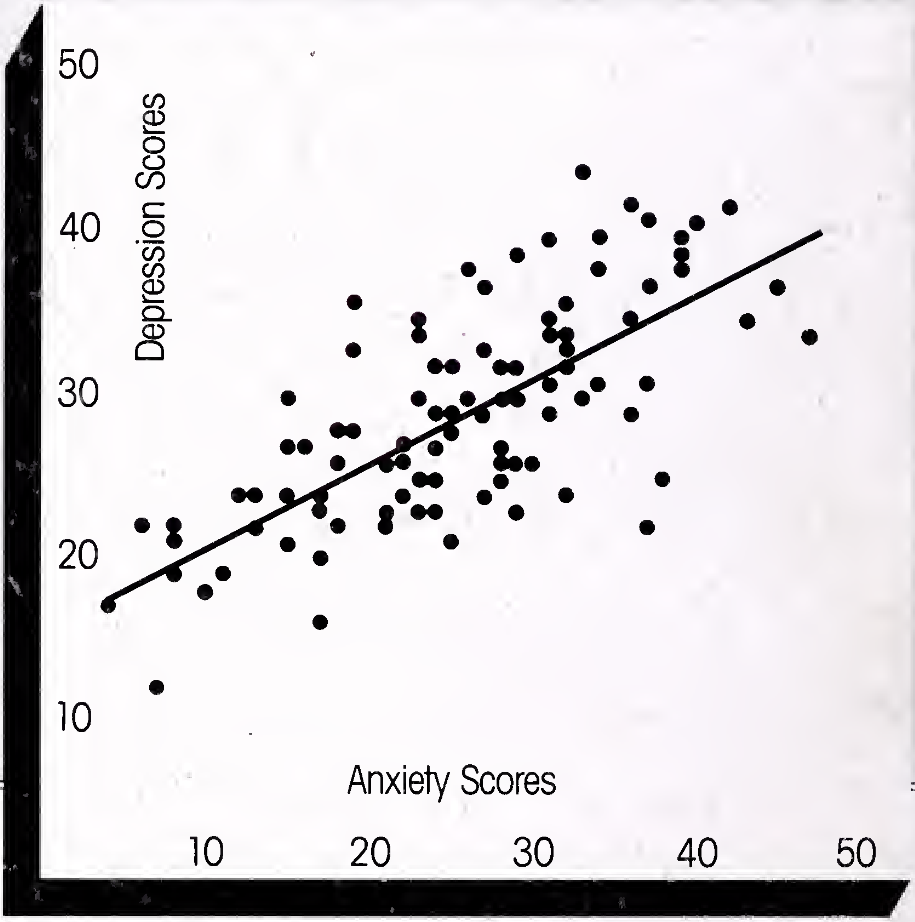
MORE DEPRESSION MEANS MORE ANXIETY...



The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scale in 100 nonpsychotic psychiatric patients. The Coefficient of Correlation is 0.7. As depression increased, so did the anxiety levels.

—Adapted from Claghorn J[1]

A key reason why

MORE PHYSICIANS ARE CHOOSING LIMBITROL®

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Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

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[1] Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970

Please see summary of product information on inside cover.

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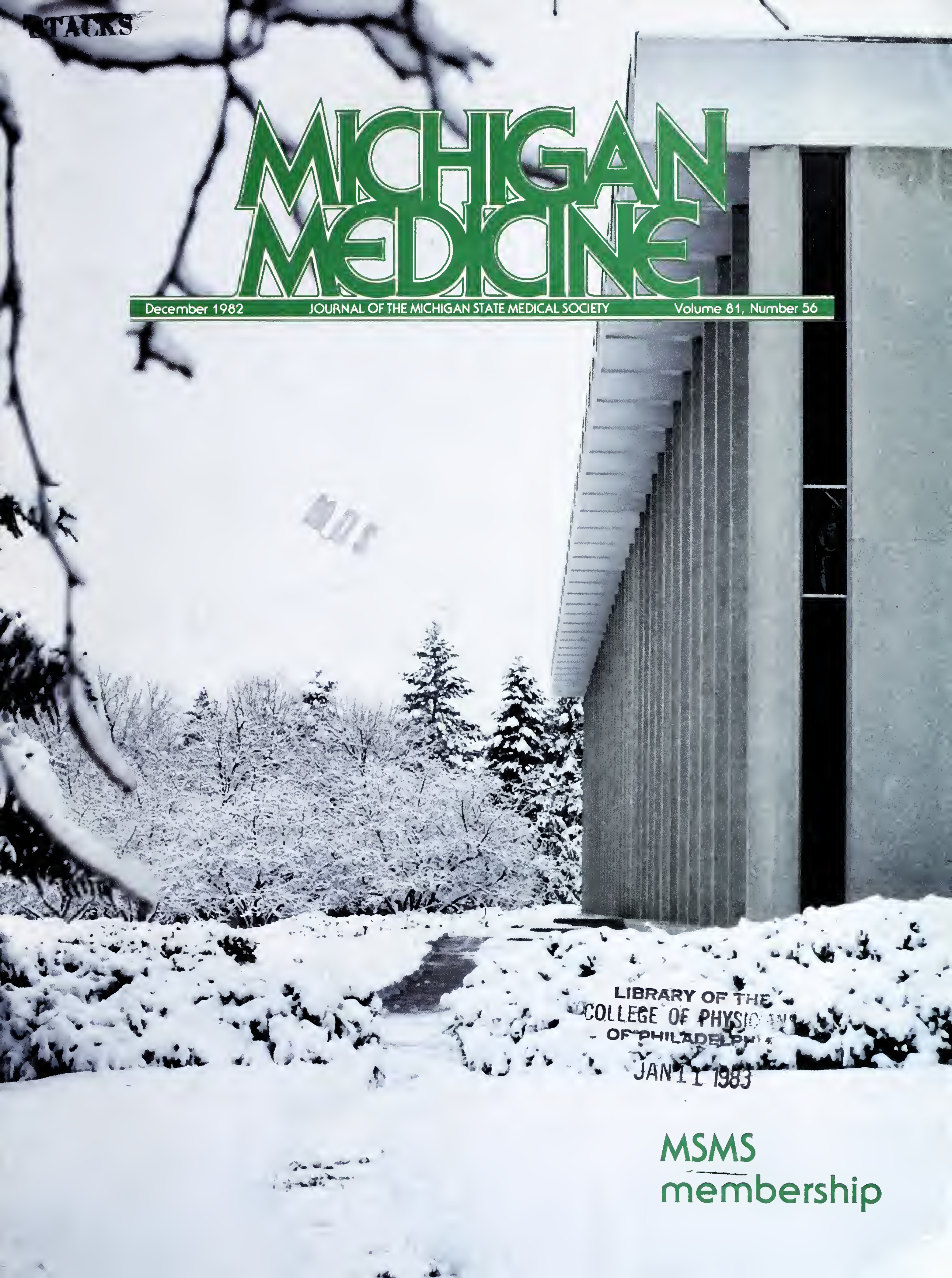

MICHIGAN MEDICINE

December 1982 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 81, Number 56

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MSMS
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MSMS ADDRESS: Michigan State Medical Society
120 West Saginaw (Box 950)
East Lansing, MI 48823

MSMS PHONE: 517/337-1351

Michigan State Medical Society Membership Insurance Benefits

Are you aware of the insurance available to you as an MSMS member?

On the following two pages is a summary of the member benefit insurance coverages which are available to you through the Michigan State Medical Society. All members are encouraged to review this information to be fully aware of all the benefits available and to determine if and where these coverages may fill a void or supplement your existing insurance program.

Any questions or comments regarding these programs may be directed to Wayne Burmeister, manager, Department of Operations and Member Services, Michigan State Medical Society Headquarters, 120 W. Saginaw, East Lansing, 48823 (Telephone — 517/337-1351).

Please remove this insert for handy reference in your files.

Insurance benefits available for Michigan State Medical Society members

Type	Coverage Available	Special Features	Administrators	Eligibility/How to Apply
1. **Disability Income Protection Accident & Sickness**	Optional amounts up to $1,500 monthly benefit. Benefits paid from the 1st & 16th day, 30th day, or 90th day of disability; and, benefit duration is lifetime for accident and up to age 65 for sickness, depending on the plans selected. Coverage automatically includes waiver of premium, accidental death & dismemberment coverage, up to 7 days indemnity for non-disabling injuries, & partial disability payments. The plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	New members guaranteed $500 monthly benefit, regardless of medical history. Indemnity paid for first 15 days of hospital confinement for sickness. Guaranteed conversion if member leaves the state to continue full time practice in another state. Claims not pro-rated because of benefits received from other insurance.	Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All MSMS members, under age 75, residing in Michigan, practicing full-time, may apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free, (Michigan) 1-800-292-1966.
2. **Business Overhead Disability Coverage**	Optional amounts up to $3,000 monthly benefit. Reimbursement for office expenses; i.e., rent, employees' salaries, utilities, malpractice insurance premiums, etc., during a period of total disability. Benefits payable from the 16th day of disability. Benefits are payable until the Maximum Overhead Expense Benefit Limit is reached — which is the monthly benefit times twenty-four. Waiver of premium is automatically included. The plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premiums constitute a business expense and are deductible from gross income before taxes (IRS, 55-264, I.R.B. 1955-19, p. 8).	Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All MSMS members residing in Michigan who practice full-time are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & Information, or Toll Free, (Michigan) 1-800-292-1966.
3. **Term Life Insurance**	Available in amounts of $25,000, $50,000, $75,000 or $100,000. Renewable to age 70 (amount reduced at age 65). Waiver of premium is included. Full conversion available to the Permanent Life Insurance Plan after policy is in force one year. This plan is underwritten by The Mutual Benefit Life Insurance Company, Newark, New Jersey.	New MSMS members guaranteed $25,000, regardless of medical history. Participating members are eligible to share any dividends that become payable. Guaranteed conversions to ordinary life if membership is discontinued. Conversions also available to Permanent Life at age 65 reduction and age 70 termination.	Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All members, under age 70, active full time in a professional position, are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan) 1-800-292-1966.
4. **Special Accidental Death & Dismemberment Benefits**	Provides benefits for loss of life, limbs, or sight as the result of an accident in amounts of $25,000, $50,000, $75,000, or $100,000. Coverage for the spouse may be purchased — the amount will be 50% of the member's principal sum. This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Around-the-clock protection and world-wide coverage. Sports and recreation as well as professional duties are fully covered. Renewable to age 70.	Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All MSMS members, under age 70, engaged full time in their profession in the State of Michigan are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.
5. **Disability Income Protection For Employees of Members**	Available in various amounts up to $500 monthly benefit. Choice of 7-day, 15-day, or 30-day waiting period for benefits to begin. Two benefit durations available: one-year accident/one-year sickness; and, five-years accident/two-years sickness. Waiver of premium included. This plan is underwriten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premium is a tax deductible expense when paid by the employer.	Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	Employees, under age 60, who are employed full time by an MSMS member. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.
6. **MEDGARD Professional Liability Insurance**	Limits of $100,000/$300,000; $200,000/$600,000; $1,000,000/$1,000,000 available in occurrence policy forms. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan — a physician-owned company.	A 75% premium discount to first-year practitioners; 50% for most part-time or semi-retired physicians. No charge for P.C./partnership coverage. Premium financing available.	Stratton-Cheeseman Management Company, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	Write or call Michigan Physicians Mutual Liability Company for a free introductory kit. Telephone numbers are: East Lansing (517) 351-1150; Birmingham (313) 647-5550; or toll free (800) 292-1926.
7. **MEDGARD Property & Liability Insurance**	Comprehensive property & liability insurance for physicians' offices and other property. Selection of optional coverages. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan.	Broadest all-risk replacement cost coverage. Insurance designed specifically for physicians. Competitively priced. Advantage of one company — total coverage.	Stratton-Cheeseman Management Company, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	Write or call Michigan Physicians Mutual Liability Company for specific information. Telephone numbers are: East Lansing (517) 351-1150; Birmingham (313) 647-5550; or toll free (800) 292-1926.
8. **Hospital/Medical/Major Medical Dimension III**	Excellent benefits to cover hospital, medical and major medical services. A separate benefit program is available for employees.	Three option coverages available to physicians and their families, from comprehensive total benefits to Dimension III with deductibles and copayments and a lower premium.	Blue Cross and Blue Shield of Michigan 600 Lafayette East Dept. J113 Detroit, MI 48226	Available to all MSMS members and their employees. Enrollment kit is available from MSMS Department of Member Services, 120 W. Saginaw St., East Lansing, 48823, (Tel. 517/337-1351).

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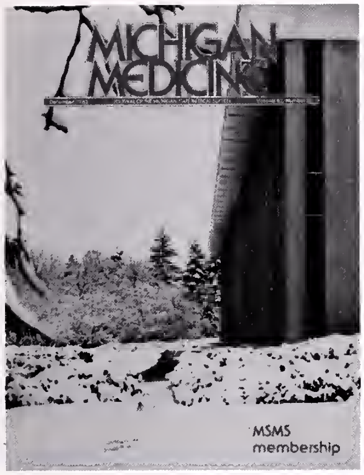
*1979. The National Underwriter Company



MSMS headquarters graces the cover of this issue, to point to the special report inside which highlights the benefits of belonging. **(Cover photo by Mert Scholten)**

MICHIGAN MEDICINE
December 1982, Vol. 81, No. 56

Special report

668 There are many good things about membership in MSMS, your growing, strengthening, ever more active professional association. In this issue, we highlight some of the current membership activities. And from cover to back pages, we offer features which describe the organization and the people who comprise it. We hope you will keep this issue as a reference throughout the year to MSMS Programs and benefits, and invite you to share it with a non-member physician friend; Billy Ben Baumann, MD; Robert M. Leitch, MD

Features

665 MSMS officers and councilors

681 MSMS Public Affairs/Leadership Conference presents complicated picture of physicians' economic future; Charles R. Downs, Judith Marr

688 MSMS committees, their purpose and members

704 Letters, phone calls to MSMS reflect the times; Kim Dean

710 MSMS position paper tackles issue of certifying physician competency

Departments

664 In my opinion; Busharat Ahmad, MD

676 MSMS/A; Jane Mueller

696 Medico-legal

699 Financial planning/investment perspectives; Daniel Ludwin

703 New members

706 News; Debbie Lange

708 Category I courses

709 Deaths

712 Classified ads

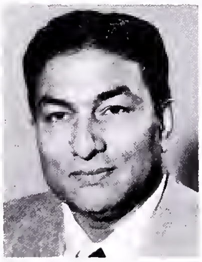
713 Ad index

714 President's page

IN MY OPINION

MSMS is the future

By Busharat Ahmad, MD
Marquette



I joined Marquette-Alger County Medical Society and the Michigan State Medical Society in 1971 when I moved to Michigan. I joined because at that time it was the thing to do. Since then I have realized how many benefits I have gained from this membership. I would just like to share a few with you.

During the malpractice crisis of the 1970s MSMS helped to organize Michigan Physicians Mutual Liability Company and helped me obtain my insurance at a reasonable price. Since then they have kept on top of the malpractice situation and I feel happy that MPMLC is my insurer.

The MSMS Physician Service Group has helped me a lot to organize my practice, my office, and my pension and profit-sharing plan. The PSG people have provided me with straight forward, honest advice which has saved me a lot.

The annual CME courses give me almost all the credits I need to keep my license.

The MSMS publications, *Michigan Medicine* and *Medigram*, are very educational.

MSMS keeps me informed about dealings with third-party carriers like Blue Cross/Blue Shield, Medicaid and Medicare.

The other membership services like the credit card billing program, mailing lists and CME credit list, make my life easier.

I have the privilege of attending the House of Delegates and the Council meetings and thus the pleasure of working with dedicated, sincere, hard working physicians who devote much of their time for the benefit of their MSMS colleagues. If you have not attended one of their meetings, you should; it will open your eyes to the importance of organized medicine. The amount of time that these people put in just in the FTC case has been over and above the call of duty.

Lastly, I enjoy the company of my colleagues and the opportunity to discuss socio-economic issues with them at county medical society meetings.

These are just a few advantages that I have received as a member of the Michigan State Medical Society. If you are not a member of this organization, please become one; this is where the future lies.

Doctor Ahmad is chairman of the MSMS Committee on Publications. He is an ophthalmologist.

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Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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MSMS leaders work to serve membership

1983 MSMS officers and leaders pose for their official portrait. They are, from left, back row, Joel Clay, MD, District 15; Billy Ben Baumann, MD, District 15; Donald N. Sweeny, Jr., MD, District 1; Frank B. Walker, MD, District 1; James J. Humes, MD, District 1; Kornelius Van Goor, MD, District 5; Justin L. Sleight, MD, District 2; Arthur Ulmer, MD, District 1; Richard L. Rapport, MD, District 6; Kenneth B. Herrington, MD, District 7; and Kenneth E. Rowe, MD, District 13. From left, second row, are Frederick W. Bryant, MD, District 15; Harvey M. Andre, MD, District 5; Robert D. Burton, MD, vice speaker; Leland E. Holly II, MD, treasurer; Robert E. Paxton, MD, District 11; Jack L. Barry, MD, District 8, and Dean P. Carron, MD, District 14. From left, front row, are James H. Tisdel, MD, president; Donald K. Crandall, MD, president-elect; Thomas R. Berglund, MD, chairman; Gerald H. Mandell, MD, speaker; Busharat Ahmad, MD, District 12; William D. Walters, MD, District 3; and Robert M. Leitch, MD, secretary. Not shown are James D. Fryfogle, MD, past president; Richard J. McMurray, MD, AMA delegation representative to the Council; Carl A. Gagliardi, MD, vice chairman; Kenneth J. Ray, MD, District 1; Vickers C. Hansen, MD, District 9, and Charles L. Oppy, MD, District 10.

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	Kornelius Van Goor, MD, Grand Rapids
District 6	Richard L. Rapport, MD, Flint
District 7	Kenneth B. Herrington, MD, Bad Axe
District 8	Jack L. Barry, MD, Saginaw
District 9	Vickers C. Hansen, MD, Manistee
District 10	Charles L. Oppy, MD, Roscommon
District 11	Robert E. Paxton, MD, Fremont
District 12	Busharat Ahmad, MD, Marquette
District 13	Kenneth E. Rowe, MD, Hancock
District 14	Dean P. Carron, MD, Ann Arbor
District 15	Billy Ben Baumann, MD, Pontiac
	Frederick W. Bryant, MD, Royal Oak
	Joel W. Clay, MD, Mt. Clemens

Candidates for nutritional therapy...

10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socioeconomic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]

Before prescribing, please consult complete product information, a summary of which follows:
Each Berocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.
Contraindications: Hypersensitivity to any component.
Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
Adverse Reactions: Adverse reactions have been reported with specific vitamins and

ROCHE®

5,000,000 hospital patients with infections.[4] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[3]

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.[5]

Berocca Plus
A balanced formula for prophylactic or therapeutic nutritional supplementation.
Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc), plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

Berocca Plus,
highly acceptable to patients, has virtually no odor or aftertaste and is economical. And its "Rx only" status means more physician involvement, better patient compliance.

References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.
Dosage and Administration: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.
How Supplied: Golden yellow, capsule-shaped tablets—bottles of 100.

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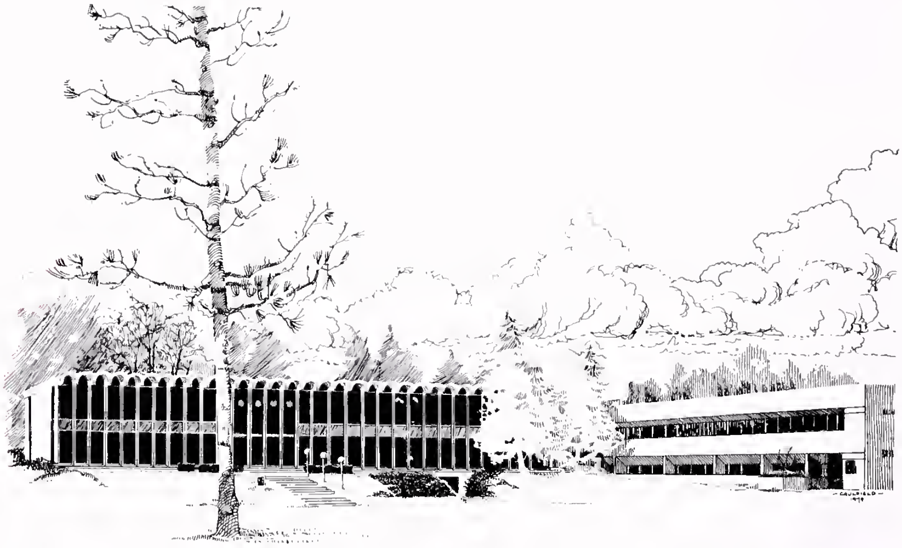


MSMS reaching out to invite new members

**By Billy Ben Baumann, MD
Pontiac**

If you are reading this article, chances are you already are an MSMS member. My question to you is: when did you last ask another physician to join our organization?

Membership recruitment is never easy; given the current economic climate in Michigan most professional organizations are considering themselves lucky to simply retain existing members.

MSMS membership numbers happily continue to grow, although not as rapidly as we might like. I want to share with you a couple of numbers to demonstrate our current status and our potential.

As of November 1, MSMS had a total of 9,946 members. This includes both dues-paying and dues-exempt members. While the figure is just below the early 1982 statistic when Doctor Keith Miyamoto became our 10,000th MSMS member, we fully anticipate regaining the number before year's end.

Like any other professional organization, MSMS is growing older, as increasing numbers of members move into retired or life status. This means we must work harder to replace those numbers (and their attendant loss in dues income). We have added 497 new members in 1982 while losing 418 due to nonpayment of dues, death and outmigration. This means a net gain of 79 members — no phenomenal growth, yet better than maintaining the status quo or backsliding.

We need the help of every member to "sell" membership to the nonmembers in our ranks. Peer to peer recruitment can and does work; but it takes an effort and a sense of dedication.

Your MSMS membership committee is conducting, in cooperation with the AMA membership department, an active direct mail campaign which will reach all non-members six times in the coming months. Many of our component societies are making local recruiting efforts as well.

MSMS has held several social gatherings for residents in some of the major teaching hospitals in an effort to acquaint these physicians-in-training with our organization and its activities. The most recent of these was held in early November at Harper-Grace Hospital in Detroit where a good turnout of residents was on hand for pizza and a chance to learn more about membership in MSMS.

We have an active and rapidly growing group of medical students who are busy talking about MSMS membership with their fellow students on all three medical school campuses.

It is encouraging to see the interest and enthusiasm that these young people have for organized medicine, a spirit which was almost nonexistent during the turmoil of the late 60s. I believe our future lies with these young doctors and students. We must attract and hold their interest in order to assure the future of their profession.

Your membership committee cannot do the job alone, however. We need the help of every member who believes in organized medicine.

Be certain your county medical society has an efficient, noncumbersome system of approving new membership applications and transfers. Be certain it has some mechanism, even a simple one, of recruiting new members on a continuing basis. Talk to non members. Invite them to join your county society, MSMS and AMA. Together we can do something about the problems confronting us.

We are facing many issues today in medicine which will impact not only on our practice lives, but particularly on the lives of the physicians just getting into the profession. I will not enumerate the problems here, but I do believe that the challenge is before us to surmount them. We need a strong, united organization to meet the challenge.

To have that numerical strength each of us must do our part. We've discovered that far too often a physician has never joined our ranks because he or she simply has never been asked! Make a point to ask someone to join us today!

Doctor Baumann is chairman of the MSMS Committee on Membership Recruitment and Retention.

Every component society has a link

A year ago MSMS rekindled a campaign to visit as many as possible of the 55 component societies of the Michigan State Medical Society.

MSMS Councilors and staff were assigned component medical societies and given a goal of contacting at least 75 percent of their assigned counties. Last year's program was a resounding success with MSMS representatives visiting 77 percent of the component counties.

Several of the component society officers commented on the timeliness of this new endeavor. One county leader said that the county membership needs to be more informed of the activities of the state society. Another county society membership reported gratefully their largest gathering in memory when MSMS officers attended a meeting.

It is our goal in the '82-'83 program, not only to contact the county societies not visited in the previous program, but also to again exceed the 75 percent level of component societies' visits and/or contacts.

Here is the listing of MSMS Councilor and staff assignments for the 1982-1983 Component Society Visitation Program.

If you have further questions regarding leadership and staff attending component society meetings, please contact William Madigan at MSMS headquarters.

ALLEGAN COUNTY
Councilor: Thomas R. Berglund, MD
Staff: Sherry Wellman

ALPENA-ALCONA-PRESQUE-ISLE COUNTIES
Councilor: Charles L. Oppy, MD
Staff: Dennis Paradis

BAY-ARENAC-IOSCO COUNTIES
Councilor: Charles L. Oppy, MD
Staff: Wayne Burmeister

BERRIEN COUNTY
Councilor: Thomas R. Berglund, MD
Staff: Sherry Wellman

BRANCH COUNTY
Councilor: William D. Walters, MD
Staff: Dennis Paradis

CALHOUN COUNTY
Councilor: William D. Walters, MD
Staff: Wayne Burmeister

CASS COUNTY
Councilor: Thomas R. Berglund, MD
Staff: Sherry Wellman

CHIPPEWA-MACKINAC COUNTIES
Councilor: Busharat Ahmad, MD

CLINTON COUNTY
Councilor: Justin L. Sleight, MD
Staff: Mert Scholten

DELTA COUNTY
Councilor: Busharat Ahmad, MD
Staff: Sherry Wellman

DICKINSON-IRON COUNTIES
Councilor: Kenneth E. Rowe, MD

EATON COUNTY
Councilor: Justin L. Sleight, MD
Staff: Vada Davis

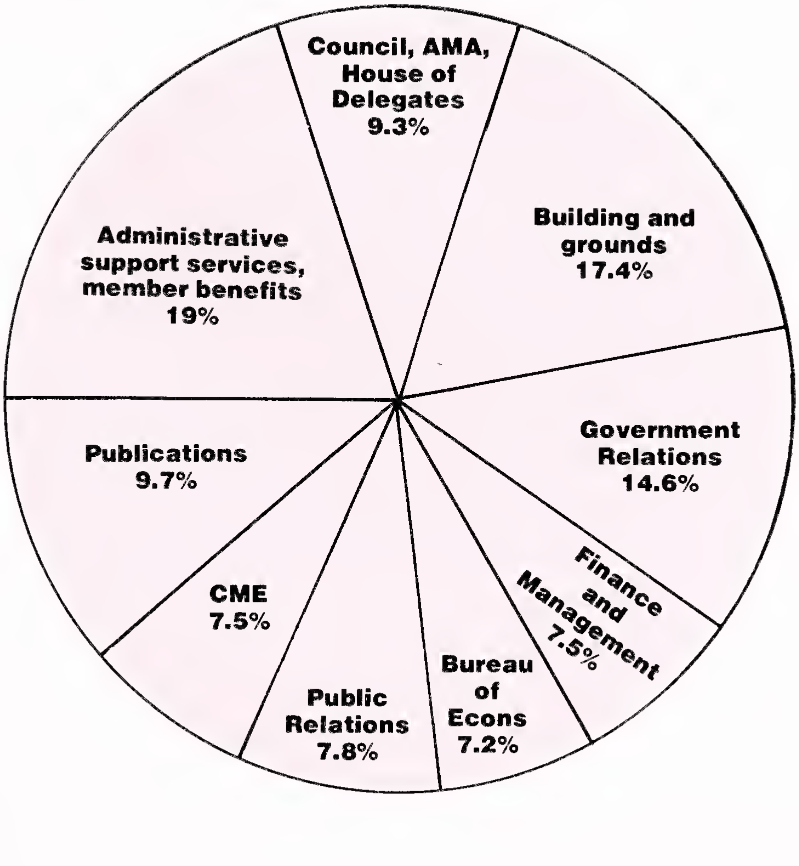
GENESEE COUNTY
Councilor: Richard L. Rapport, MD
Staff: William Madigan

Where do your dues go?

Membership fees for your state medical society, which are $260 for 1983, are parceled out prior to the MSMS fiscal year which begins Dec. 1. Making the decisions are members of the Finance Committee of the MSMS Council, chaired by Robert Paxton, MD, Fremont.

The Finance Committee acts on the recommendations of the MSMS Budget Subcommittee to the Finance Committee and spends many hours during the fall months analyzing every projected expense and revenue item. They obtain final approval for the budget from the MSMS Council.

The pie chart here illustrates the distribution of MSMS income from dues and other sources to MSMS program areas. It is to give MSMS members a clearer idea of how MSMS revenues are spent.



GOGEBIC COUNTY
Councilor: Kenneth E. Rowe, MD

GR. TRAVERSE-LEELANAU-BENZIE COUNTIES
Councilor: Vickers C. Hansen, MD
Staff: Richard Campau

GRATIOT COUNTY
Councilor: Jack L. Barry, MD
Staff: Kevin Kelly

HILLSDALE COUNTY
Councilor: Justin L. Sleight, MD
Staff: Vada Davis

HOUGHTON-BARAGA-KEWEENAW COUNTIES
Councilor: Kenneth E. Rowe, MD

HURON COUNTY
Councilor: Kenneth B. Herrington, MD
Staff: William Madigan

INGHAM COUNTY
Councilor: Justin L. Sleight, MD
Staff: Judy Marr

IONIA-MONTCALM COUNTIES
Councilors: Harvey M. Andre, MD
Kornelius Van Goor, MD
Staff: John Anthony

ISABELLA-CLARE COUNTIES
Councilor: Jack L. Barry, MD
Staff: Vada Davis

JACKSON COUNTY
Councilor: Justin L. Sleight, MD
Staff: John Richards

KALAMAZOO COUNTY
Councilor: Thomas R. Berglund, MD
Staff: Warren Tryloff

KENT COUNTY
Councilors: Harvey M. Andre, MD
Kornelius Van Goor, MD
Staff: Bruce Ambrose

LAPEER COUNTY
Councilor: Kenneth B. Herrington, MD
Staff: Richard Campau

LENAWEE COUNTY
Councilor: Dean P. Carron, MD
Staff: Linda Munson

LIVINGSTON COUNTY
Councilor: Dean P. Carron, MD
Staff: John Anthony

LUCE COUNTY
Councilor: Busharat Ahmad, MD

MACOMB COUNTY
Councilor: Joel W. Clay, MD
Staff: Kevin Kelly

MANISTEE COUNTY
Councilor: Vickers C. Hansen, MD
Staff: Wayne Burmeister

MARQUETTE-ALGER COUNTIES
Councilor: Busharat Ahmad, MD
Staff: Sherry Wellman

MASON COUNTY
Councilor: Robert E. Paxton, MD
Staff: John Richards

MECOSTA-OSCEOLA-LAKE COUNTIES
Councilor: Robert E. Paxton, MD
Staff: Kevin Kelly

MENOMINEE COUNTY
Councilor: Busharat Ahmad, MD
Staff: Sherry Wellman

NORTH CENTRAL COUNTY
Councilor: Charles L. Oppy, MD
Staff: Debbie Zannoth

MIDLAND COUNTY
Councilor: Jack L. Barry, MD
Staff: Dennis Paradis

MONROE COUNTY
Councilor: Dean P. Carron, MD
Staff: Bruce Ambrose

MUSKEGON COUNTY
Councilor: Robert E. Paxton, MD
Staff: John Anthony

NEWAYGO COUNTY
Councilor: Robert E. Paxton, MD
Staff: William Madigan

NORTHERN MICHIGAN
Councilor: Vickers C. Hansen, MD
Staff: Richard Campau

OAKLAND COUNTY
Councilors: Frederick W. Bryant, MD
Billy Ben Baumann, MD
Staff: Warren Tryloff

OCEANA COUNTY
Councilor: Robert E. Paxton, MD
Staff: John Anthony

ONTONAGON COUNTY
Councilor: Kenneth E. Rowe, MD

OTTAWA COUNTY
Councilors: Harvey M. Andre, MD
Kornelius Van Goor, MD
Staff: Mert Scholten

SAGINAW COUNTY
Councilor: Jack L. Barry, MD
Staff: Dennis Paradis

ST. CLAIR COUNTY
Councilor: Kenneth B. Herrington, MD
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Councilor: William D. Walters, MD
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Councilor: Kenneth B. Herrington, MD
Staff: Sherry Fent

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Councilor: Busharat Ahmad, MD
Staff: Sherry Wellman

SHIAWASSEE COUNTY
Councilor: Richard L. Rapport, MD
Staff: Mert Scholten

TUSCOLA COUNTY
Councilor: Jack L. Barry, MD
Staff: William Madigan

VAN BUREN COUNTY
Councilor: Thomas R. Berglund, MD
Staff: John Richards

WASHTENAW COUNTY
Councilor: Dean P. Carron, MD
Staff: John Richards

WAYNE COUNTY
Councilors: Carl A. Gagliardi, MD
James J. Humes, MD
Kenneth J. Ray, MD
Donald N. Sweeny, MD
Arthur A. Ulmer, MD
Frank B. Walker, MD
Staff: Warren Tryloff

WEXFORD-MISSAUKEE COUNTIES
Councilor: Vickers C. Hansen, MD
Staff: Wayne Burmeister

MSMS, MPMLC work closely to maintain best malpractice climate

By Robert M. Leitch, MD
Battle Creek

As a result of the "malpractice crisis" of 1975, the availability of professional liability insurance in Michigan was severely constricted to the point that we were in danger of losing a significant number of our physicians. The cost of insurance was rising exponentially, further complicating the problem. In the midst of these difficult times, MSMS became the driving force in the formation and development of Michigan Physicians Mutual Liability Company.

The officers of this fledgling company were gleaned from the Michigan State Medical Society leaders who desired to solve the availability and affordability issues for our members. With $3 million surplus, contributed by individual physicians, medical organizations, and Blue Cross/Blue Shield of Michigan, the company issued its first policy in June, 1976.

During the ensuing six years we have grown to become a major insurance company with assets of $95 million. As of 10-22-82, we insured 4,565 physicians for primary professional liability, 698 physicians for $1 million umbrella or excess insurance, and provided 631 MEDGARD Building and Office Package Policies. We presently have $11.8 million in surplus and $70.5 million in reserves for losses.

Leading writer

Michigan Physician's Mutual is listed in BEST'S REVIEW as the state's leading writer of professional liability insurance for physicians. We had a 23.1 percent market share in 1980. This increased slightly in 1981 to 23.3 percent of the market. Michigan is ranked fifth in the nation in terms of total direct premiums ($75.67 million) following, in order, New York, California, Illinois, and Ohio.

In 1977, we expanded the base of our insureds by offering insurance to osteopathic physicians who were experiencing the same problems the MDs had been through two or three years previously. Now we have a ratio of approximately two MDs to one DO in insureds. We have received the endorsement of the Michigan State Medical Society and the Michigan Association of Osteopathic Physicians and Surgeons as the "official" company of these two organizations.

We cooperate with the physicians' professional organizations in the development of programs in the area of professional liability. MSMS currently is offering a program on good medical record-keeping as a risk management tool. This program has been developed by the MSMS Risk Management Committee largely from

Doctor Leitch is president of the Michigan Physicians' Mutual Liability Company. A family physician, he also is secretary of MSMS.

MSMS is . . .

- **An active, growing entity of more than 10,000 members dedicated to the practice of quality medicine and the highest ideals of patient care.**
- **An association of the medical doctors of Michigan, open to any licensed MD or DO who voluntarily agrees to abide by the constitution and bylaws of the organization.**
- **An organization which ensures that physicians' voices are heard on matters of professional concern.**
- **A voluntary organization dedicated to the continuing medical education and professional improvement of its membership so that the people of Michigan can enjoy the best possible health care.**
- **A group of physicians dedicated to cost effective medical care rendered with concern, quality, and humanity.**
- **A state component society of the American Medical Association (AMA) assuring national representation for Michigan medicine.**

MSMS membership means . . .

Accessibility to a wide range of services and benefits. MSMS serves as medicine's voice to the Michigan public, legislature, health planning groups, and government executive departments.

As the medical profession is faced with unprecedented challenges from virtually every front, the scope of MSMS activities continues to expand. The Society is actively involved in all areas of concern to Michigan physicians — from peer review and practice management to legislation and continuing medical education.

In addition, MSMS offers member physicians tangible benefits such as: insurance programs; CME seminars; travel packages for physician and family; car lease plans; management and consulting services; and publications providing current information on legislative, political, and socioeconomic developments affecting the practice of medicine.

MSMS physicians have joined together because of the common belief that a strong, concerted effort from medicine is necessary if the best interests of both the profession and the public are to be served. They believe further that ethical and educational standards are most properly set, monitored, and maintained by the profession itself.

If medicine is to influence national, state, and local decisions, all physicians must be willing to assume leadership roles. They must be willing to accept committee appointments, media interviews, and speaking invitations. They must give their time and support and elect competent and conscientious delegates and officers.

With this backing and active participation — at both the state and local levels — the Michigan State Medical Society can ensure that medicine's voice will be heard.

MPMLC/*Continued*

materials provided by MPMLC. As the whole area of risk management expands, there will be close cooperation between our two organizations in the development and dissemination of programs.

When MPMLC was organized, it was felt that the development of risk management programs should be significant in a physician-controlled insurance company. We still feel that way. We are working to make risk management a reality with the hope that the heavy burden of professional liability will be lightened as a result.

Membership in MSMS or MAOP&S is a prerequisite to obtaining insurance with MPMLC. This is as it should be. The formation of MPMLC by MSMS has provided one of the most significant benefits of society membership in many years. The continued endorsement of MPMLC by MSMS is sincerely appreciated. Our continued requirement of medical society membership is our reciprocal acknowledgement of our close mutual relationship.

MSMS ties

As previously mentioned, the officers and board of MPMLC are comprised principally of present or former leaders of MSMS. Kenneth Ray, MD, past president of the Wayne County Medical Society and present MSMS Councilor, is a vice president of our company. Ernest P. Griffin, Jr., MD, is our secretary/treasurer and chairman of our claims committee. He is a past MSMS Council chairman and president. Other board members are: Vernon Bass, MD, former speaker of the MSMS House of Delegates and a past president; Dale Kessler, MD, chairman of our Underwriting Committee; Louis Heideman, MD, former president of the Wayne County Medical Society and of MSMS; and Donald Sweeny, MD, MSMS Councilor and prominent member of our MSMS/AMA Delegation.

There are three DO members on our Board. Doctor Frank McDevitt is a vice president of MPMLC and past president of MAOP&S. Doctor McDevitt is the immediate past president of the American Osteopathic Association. Doctor Gene Sikorski, a past president of MAOP&S, and Doctor Dean Olson complete the membership of our board.

The insurance operations of our company are ably administered by the Stratton-Cheeseman Management Company, East Lansing, under the direction of William B. Cheeseman. Stratton-Cheeseman employs over 60 individuals, all high caliber. We have a strong marketing department led by James Zwada. Our claims effort is second to none with Frank Bargeron providing the leadership in this area. There are 11 claims representatives working with Mr. Bargeron in both the East Lansing and Birmingham offices. The underwriting department is directed by David Sloan and his associates. The financial aspects of the company are overseen by William Gaugier. Not the least of our activities are our communications and risk management programs which are currently being ably directed by Gary Brown.

Members of our Board work closely with Stratton-Cheeseman staff, some of them on an almost day-to-day basis in the pursuit of excellence in the administration of the company. We are indeed fortunate to have this sound organization carrying out the policies of the board.

The future of the professional liability problem seems uncertain at this time, although the increase in the frequency and severity of the suits seems a certainty. It appears that in the states where there has been significant tort reform (a cap on awards, elimination of ad damnum, mandatory periodic payments for large claims) the problem has eased somewhat. Most of the reforms which can lead to this sort of improvement must come through legislation. This is an area where liaison between our organizations must be very close. The chance of significant legislation being enacted is greatly enhanced by pressure from organized medicine and coalitions of interested parties brought together by organized medicine. We intend to work closely in this area during the next few years.

It is my hope that the close relationship which MSMS and MPMLC now enjoy can be fostered and nurtured and that our common interests will continue to be paramount in our mutual activities.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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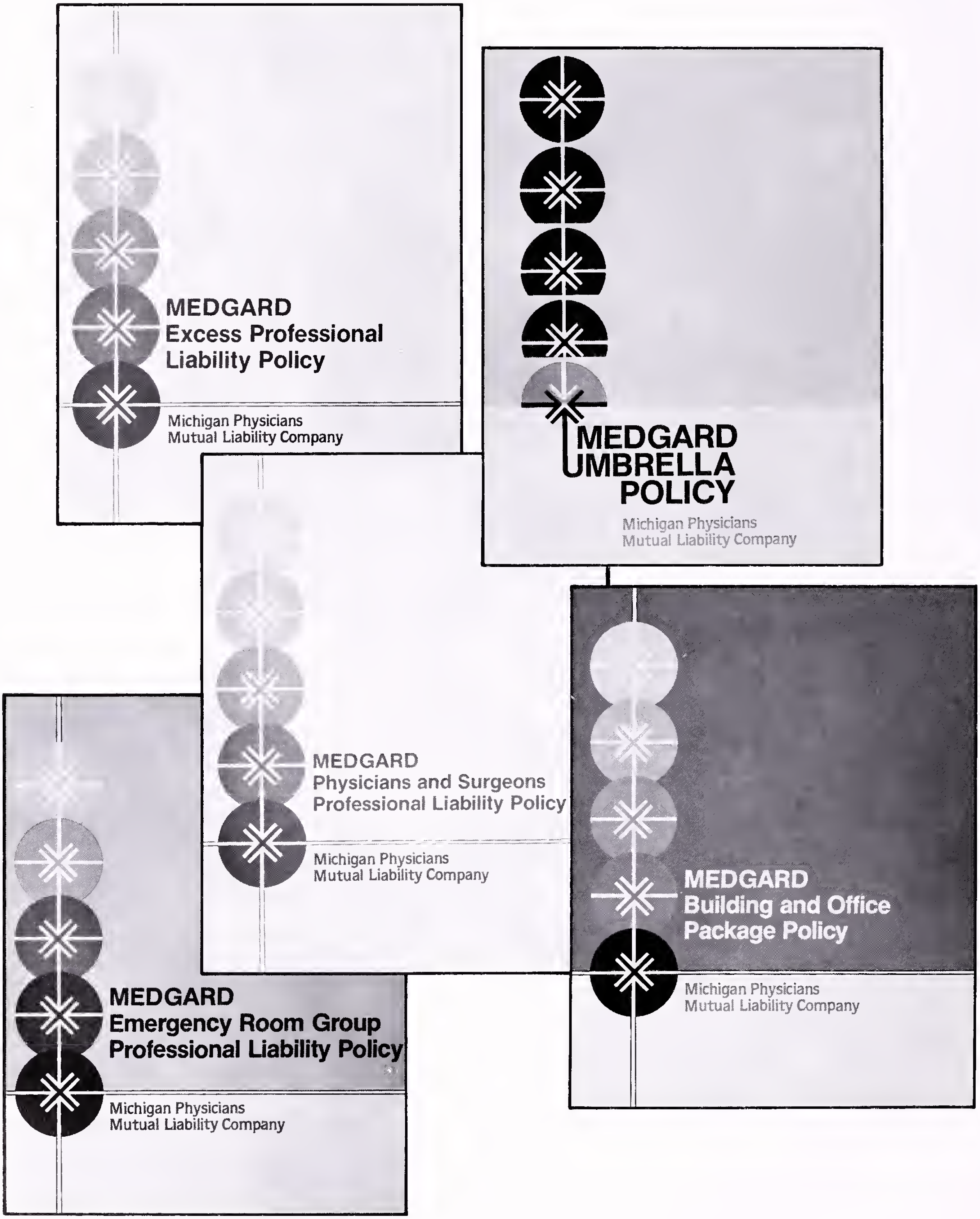

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Michigan Physicians
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Emergency Room Group
Professional Liability Policy

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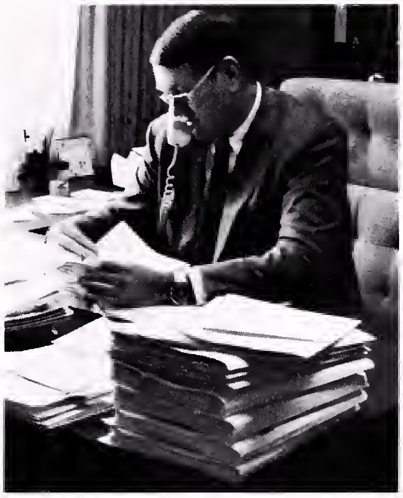
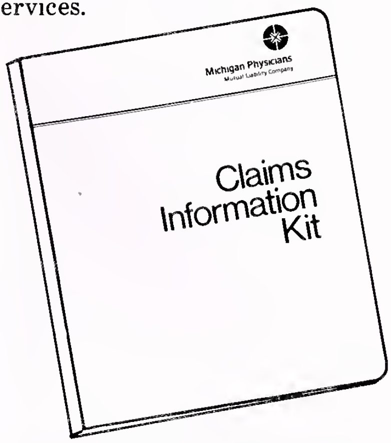
AND WHAT YOU GET.



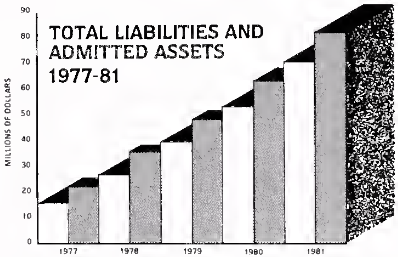
Service. Claims service is what you buy a professional liability policy for in the first place. Our policies are backed by the most experienced professional liability claims staff in Michigan. Our claims representatives return your phone calls and keep you informed of the progress of any claim in which you may be involved. These professionals and the excellent defense attorneys assigned to represent our policyholders have helped Michigan Physicians build our excellent reputation for claims services.



Communication. Our Closed Claim Questionnaire and the newly revised Claims Information Kit are examples of how we communicate with the physicians we insure. The MUTUAL MONITOR (our quarterly newsletter), risk management seminars, and special meetings at hospitals are other examples of how we are bringing information to the medical profession on a continuing basis.

Innovation. Our inhouse computer system has streamlined company operations and enabled our staff to answer your questions about underwriting or claims immediately. This system is one of the most sophisticated in the nation and our data base of claims statistics pinpoints actuarial projections and provides research information for risk management programs.

Stability. Assets of over $88 million back our policies. That's more than $20,000 for each physician insured with us for primary, professional liability. Total surplus of $11.4 million is further evidence of our financial strength and stability. In other words, our policyholders have $3 of equity for every $4 of net premium that we write annually.



Leadership. Our leaders are also your leaders. They have responded to your professional liability needs. Two years ago physicians came to us and wanted higher limits. We were the only company in Michigan to offer $1 million dollars in primary coverage to physicians in 1980. When physicians asked for excess and umbrella coverage last year, we responded with two, new policies that added the additional limits they requested. Michigan Physicians' leadership has introduced insurance products designed to meet your requirements...and lead the state with outstanding coverage for physicians.

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Membership in the medical auxiliary: Why belong?

By Jane Mueller
Saginaw

- Companionship
- Leadership training
- Educational workshops
- Serving community health needs
- Support for spouse
- Voice in legislation
- Support for medical schools
- Social and recreational activities
- Creation of good community PR
- Development of management, organizational, and creative skills

---

Mrs. Mueller is vice president and state membership chairman for the MSMS/A.

The above are just a few of the many reasons one has for joining the Medical Auxiliary.

What is auxiliary?

It is the support network for our physician spouses. It's comprised of three membership levels: county, state and national.

The national organization is the parent, offers leadership training and educational seminars, continually updating us on current issues. It speaks for us and voices our wishes to the entire nation: whether it be legislative or medical issues.

The state auxiliary is the communicator, keeping lines open between national and county, offering assistance and direction for programs; coordinating AMA-ERF and state-wide health care programs.

The county is the crucial level where the implementation of all the above occurs. County auxiliaries are the catalysts for community health activities. The county auxiliary is the

Continued on page 678

December is a gift-giving season.

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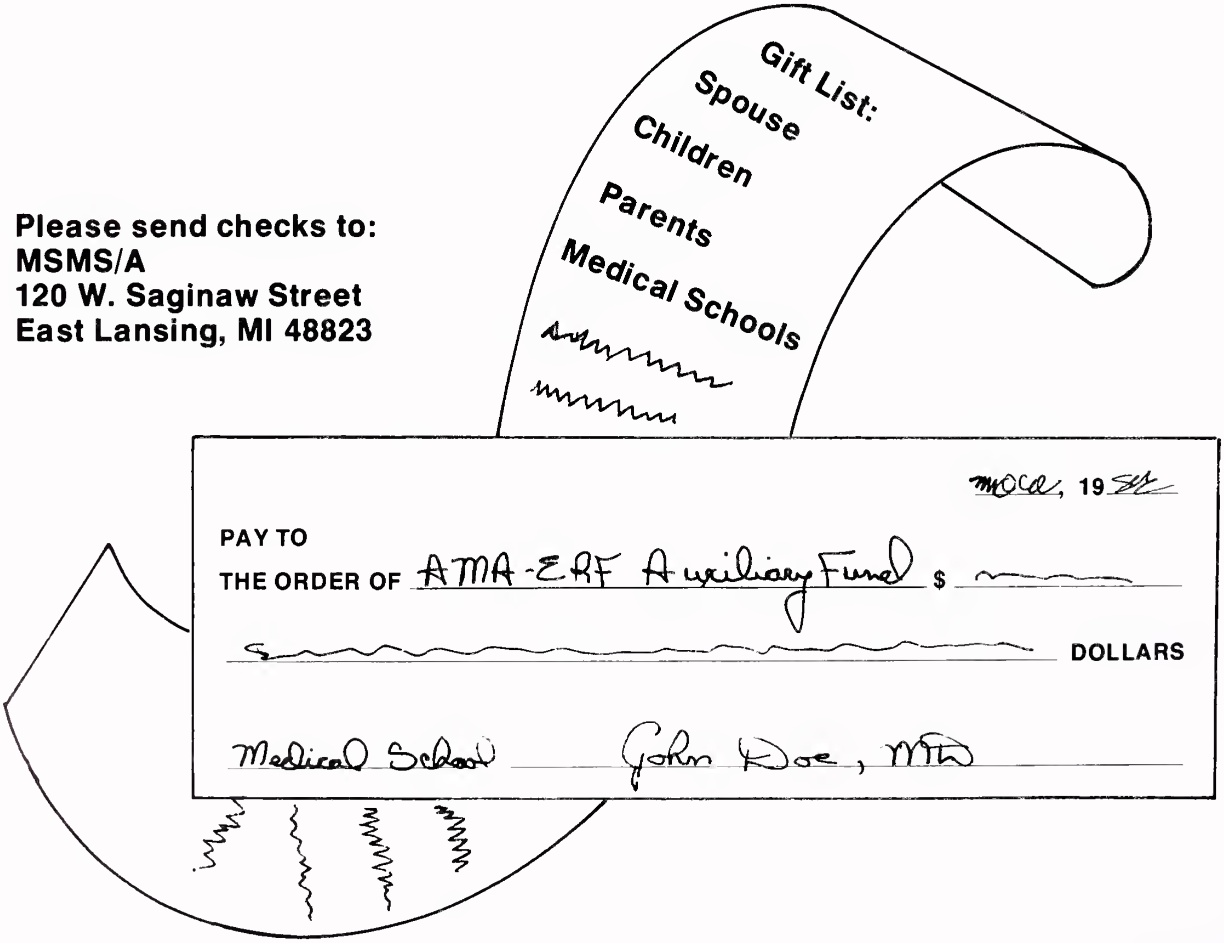

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	OTHER			
LIFE INS.	GROUP			
	PERSONAL			
EMPLOYEE BENEFITS	PENSION			
	PROFIT SHARING			
	OTHER			
STOCKS	MARKETABLE			
	CLOSELY HELD			
	BANK ACCOUNTS			
	BONDS			
	PARTNERSHIPS			
	PROPRIETORSHIPS			
TANGIBLE PERSONAL PROPERTY	FURNISHINGS			
	AUTOS, ETC.			
	SUBTRACT ALL LIABILITIES			
	TOTAL NET WORTH	$	$	$

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A portion of the crowd at the political education workshop for MSMS Auxiliary members Sept. 20 at MSMS headquarters. The workshop, which described political campaign strategy during the election year, was cohosted by the American Medical and Michigan Doctors political action committees.

support system for physicians and families through service and fellowship.

Auxiliary membership makes an impact and impression, but only through the efforts and concerns of those involved. It behooves us to be a participant either actively, by chairing or sitting on a committee, or financially.

This year we are utilizing a "buddy system." All current, active members are assigned another special auxilian. Through personal invitations to "buddies," we are encouraging more auxiliary participation.

The spouse of a conglomerate businessman is expected to entertain business associates. Some companies even dictate dress and personal contacts. The medical auxiliary allows us the opportunity to show support for our spouses and their profession. It also enables us to speak out for medicine. National membership is 80,000; that is a loud voice when spoken in unison.

Major speaker at the workshop was Roy Pfautch, Washington, DC, political research and public affairs consultant. He is pictured above with Nancy Crandall, Muskegon, wife of MSMS President Elect Donald Crandall, MD.

Recruit and retain

The key to success is getting, keeping, and motivating members. It's important to communicate. Temporary committees may help involve members. They allow good involvement from some members who might not participate otherwise, because they don't want to make a permanent commitment.

What do people want from your organization? Find out. Survey. Ask for potential members' input, their interests and concerns.

There is a wonderful feeling in belonging to and participating in an organization that makes a difference!

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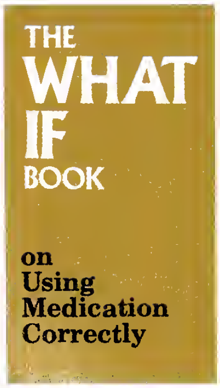
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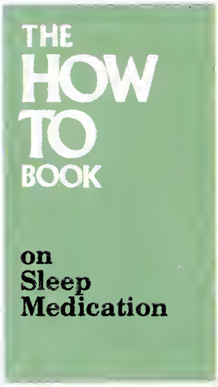
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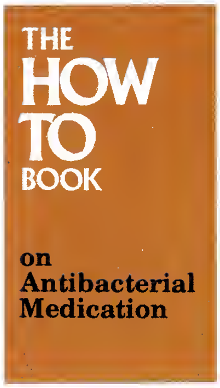
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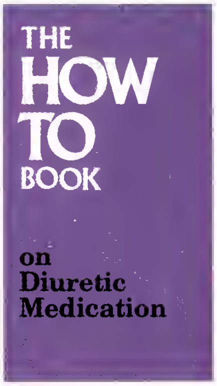
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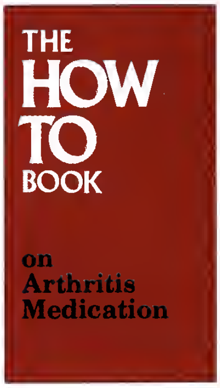
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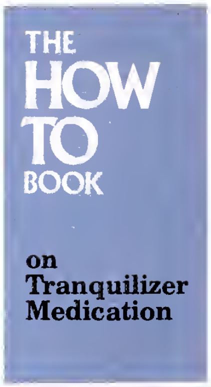
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1982 MSMS Public Affairs/Leadership Conference report:

Market forces make it necessary for physicians, hospitals to cooperate

By Charles Downs
East Lansing

There was bad news and then there was more bad news, reflected a listener after a panel of experts talked about "Market Forces Affecting Hospitals and Physicians," at the Oct. 28 MSMS Public Affairs Leadership Conference at Long's Convention Center in Lansing.

"We are all in the pot and the pot is boiling," said MSMS President-Elect Donald K. Crandall, MD, who moderated the panel.

While there may have been some differences on detail, there was agreement that forces are already at work to create change in the next few years — "the greatest change since Medicare, perhaps even greater," one panelist said. What's more, another panelist contended, the change is going to hurt physicians and hospitals to the point that some will not survive economically.

There also was consensus on a major aspect of the therapy needed — collaboration among doctors, hospitals and health care providers generally.

Change factors

Doctor Crandall pointed out some of the major factors creating change:

- Health care providers are moving from a seller's market to a buyer's market.
- Increasing numbers of physicians are coming into a depressed economy.
- Physicians are competing in some areas with other health care providers.
- New forms of health care delivery are proliferating. They are subsidized by third parties, principally government.
- Hospitals are competing for patients and at the same time HMOs are offering no choices in hospitals.

"If we are still here, we will be different at the end of this decade," said Arthur Knueppel, president of Foote Memorial Hospital in Jackson.

A number of outcomes are possible, he said, ranging from "thrival to survival." "Thrival" outcome, he maintained, calls for candid exchange of information among health professionals — determining agendas of the various coalitions, defining markets and asking patients about their needs and aspirations.

The current situation in respect to health insurance has to be understood in a historical context, said Robert Asmussen, vice president for health care operations of Blue Cross Blue Shield of Michigan.

When the Blues first began working a generation ago with unions and automobile company management in Michigan, the aim was to achieve the best in health care — "Cadillac" coverage, Asmussen said. But, he continued, when health care costs began to spiral upward in 1965, concern for health care costs started becoming "almost an obsession." He described today's health care system as being like a "freight train going down a hill and heading for a crash."

Asmussen said new ideas are coming on the horizon and will need to be examined. Chrysler Corporation, he noted, recently came close to making a dramatic changeover to HMO coverage.

Easiest targets

Jack Ryan, MD, president of the Detroit/Macomb Hospital Association, said "Health care providers are in the same boat as the car companies but without competition from Toyota."

Hospitals, he pointed out, are competing with other hospitals for patients and some are seeking mergers to avoid competition.

Attacks on the health care system, he noted, are increasing and hospitals are the easiest targets at which to shoot. He urged cooperation: "We can throw up our hands or we can seek to see opportunities."

Whitney Spaulding, director of planning of Sisters of Mercy Health Care Corporation, also discussed hospital competition. He pointed out that doctors are only beginning to face problems already encountered by hospitals, warning that government regulations are becoming increasingly restrictive in respect to medical practices, particularly current methods for computing charges.

He quoted Senator Robert Dole (R-Kansas) as saying (in respect to government regulation) that " '82 is the year of the hospitals and '83 is the year of the doctors."

"The winners," he concluded, "will be those who cooperate."

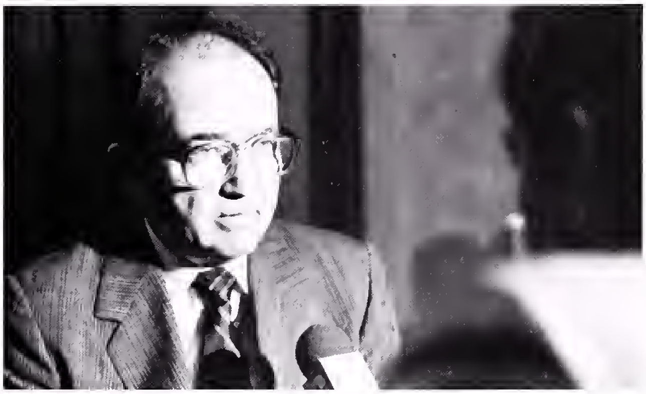
Mr. Downs is a free lance writer.

Turn page for photo highlights of conference.

The 1982 MSMS Public Affairs/Leadership Conference caused some participants, overwhelmed by the economic and political changes forecast, to speak of gloom and doom. But it also had some great lines — such as a classic Winston Churchill mother-in-law story — which brought grins from participants. From left above are Frank H. Bunker, MD, Benton Harbor; Edwin G. Vann, MD, St. Joseph, and Gideon D. Medina, MD, Niles.

Photo highlights, 1982 MSMS Public Affairs/ Leadership Conference

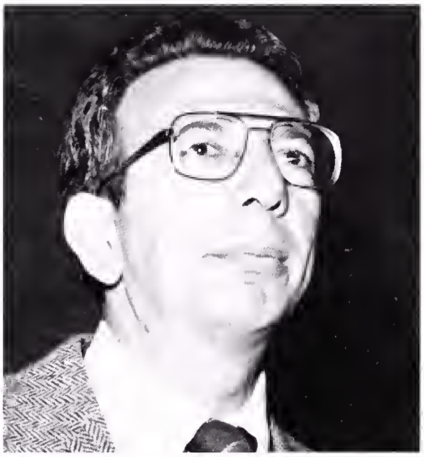
With speakers on the 1982 elections, economic trends, the AMA's priorities and market forces affecting hospitals and physicians, there were good questions from the 200-plus persons in the Lansing audience.



AMA Executive Vice President James Sammons, MD, was keynote speaker at the conference (see following pages), and was interviewed by local news media.

MDPAC Chairman Thomas C. Payne, MD, left, and Detroit's WDIV-TV political analyst Tom Greene, right, provided insight into the 1982 general elections.

General Chairman of the conference was Fred E. Patterson, MD, Ann Arbor.



Ann Arbor economist Paul Feldstein, PhD, told MDs to compete and to become politically active.

Michigan insurance commissioner Nancy Baerwaldt said she hopes the courts will address the constitutionality of the medical arbitration statute in 1983.

Doctor Sammons, who said the AMA has more major programs in effect now than at any other time in recent history, was greeted enthusiastically by many MSMS members, including Marguerite Shearer, MD, family physician, center, and Rhoda Powsner, MD, cardiologist, right, both of Ann Arbor.

Photos by Richard Wesley, Lansing

More on Leadership Conference on page 686

Tips from the Pros.

The Slant on Sidehill Shots

When you're facing uphill, with the ball resting above your feet, you should stand a bit farther from it than normal. You should also make a "flatter" swing than normal, more like a merry-go-round than a ferris wheel.

When facing downhill, with the ball below your feet, stand closer to it and swing more "upright", like a ferris wheel instead of a merry-go-round.

In either instance, it's always best to take a couple of practice swings. It's also wise to swing with less effort than normal in order to retain your balance.

The Topspin Forehand Swing

There is no wrong time to hit a topspin. If you can hit it regularly—use it. All the pros do.

The key to the topspin forehand is your ability to get under the ball and swing up quickly. The forward swing of the flat foreward drive begins as if you were sweeping off a table top with your arm. Only after you have made contact do you begin to raise your racket and finish high. And as you finish, you swing out to the court.

For the topspin forehand, the rapid upward movement from below the ball makes all the difference.

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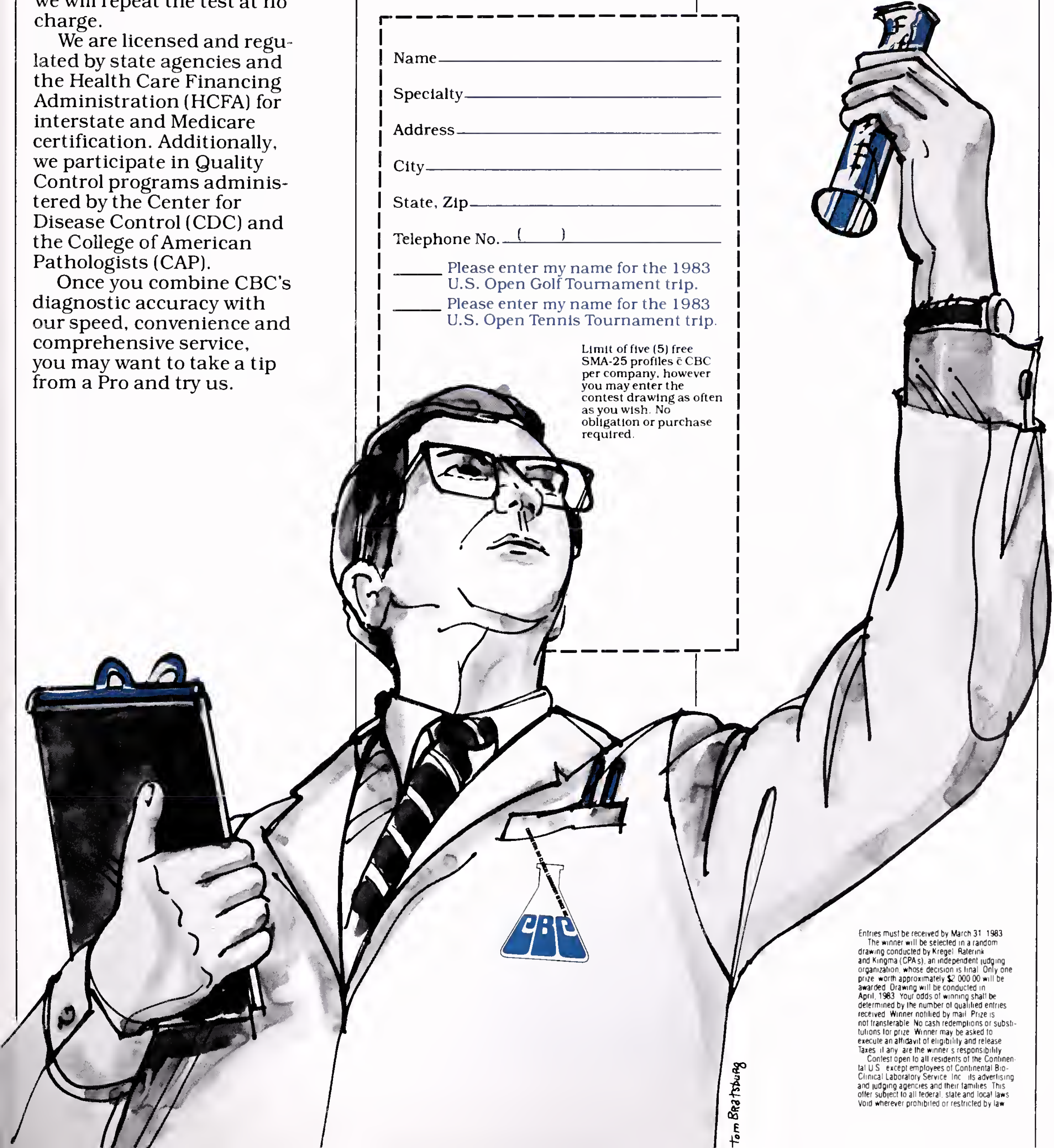

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The winner will be selected in a random drawing conducted by Kregel Raterink and Kingma (CPA s), an independent judging organization, whose decision is final. Only one prize worth approximately $2 000 00 will be awarded. Drawing will be conducted in April, 1983. Your odds of winning shall be determined by the number of qualified entries received. Winner notified by mail. Prize is not transferable. No cash redemptions or substitutions for prize. Winner may be asked to execute an affidavit of eligibility and release. Taxes if any are the winner s responsibility.

Contest open to all residents of the Continental U S except employees of Continental Bio-Clinical Laboratory Service Inc its advertising and judging agencies and their families. This offer subject to all federal, state and local laws. Void wherever prohibited or restricted by law.

AMA's priorities: Shedding FTC monkey and getting doctors to read their mail

By James Sammons, MD
Chicago

The following article is taken from remarks made by Doctor Sammons at the 1982 MSMS Public Affairs/ Leadership Conference in Lansing.

Certainly one of the AMA's top priorities is to remove the professions from the FTC's yoke. We now have the existence of an intrusion by the Federal Trade Commission in the day-to-day practice of medicine. And, we'll have other intrusions by the FTC in the accreditation process and the certification process, and if left alone and allowed to progress, into the process of licensure.

Great promise

We've got a new activity at the AMA that I think holds the potential for the greatest promise in the history of the AMA since the Flexner Report. We are developing an agenda of priorities for the American public for the next 25 to 50 years.

It will have a veritable battalion of people available to it as advisors and consultants. And it's going to require some of the toughest decision-making that this profession, as a profession, has ever had to make.

Because whether we like it or not, we are in a state of finite resources. We can no longer say "everything for everybody."

So, how does one prioritize the spending of funds? How does one, in fact, address the issue of the prioritization of the delivery of care?

Are we ultimately going to have an arbitrary decision for renal dialysis that's based on age and occupation? Are we, in fact, going to have an arbitrary decision in this country on cardiac transplants and artificial heart implacements? The latest figures I saw said that the artificial heart, rapidly approaching the point of truly being useful, would cost $100,000 a year per patient to maintain. Can this country afford that? Are we willing to do that? Who's going to make the determination as to which of those patients gets the artificial heart?

What kinds of bio-ethics is this profession going to have to live with, develop, and answer for to the American people for the next 25 to 50 years?

Don't read

The lack of information is the second greatest thing that's confronting this profession today in terms of problems.

Doctors don't read their mail. Not only do they not read it, they let an employee decide what they're going to look at. If you're guilty of that, go back to your office and change.

And for heaven's sake, open the envelopes from the Michigan State Medical Society, the AMA, your local county society, and the specialty organization that you belong to.

This is not a time when this profession can afford to be uninformed. Circumstances are changing too rapidly.

Neither is it a time when you can afford to say you're not going to belong to this or that medical organization because "they don't represent me." We can't afford that luxury at this moment in history.

Sure, the AMA does things because the House of Delegates of the AMA says do them. And you elect people to that House just like everyone else does. So literally, not just figuratively, every single doctor in this country has participated in some fashion directly or indirectly in making those decisions. And it does things that all of us, from time to time, don't agree with.

Why should your professional organization be so different? Why should it have to have slavish obedience to every single thought process that you as an individual have when you sure don't get it any place else?

Half of the doctors in America today do not belong to either the state, county or the AMA. Fifty percent of this profession is riding free. They don't spend a dime. They don't contribute in any fashion to the representation that the AMA gives them in Washington.

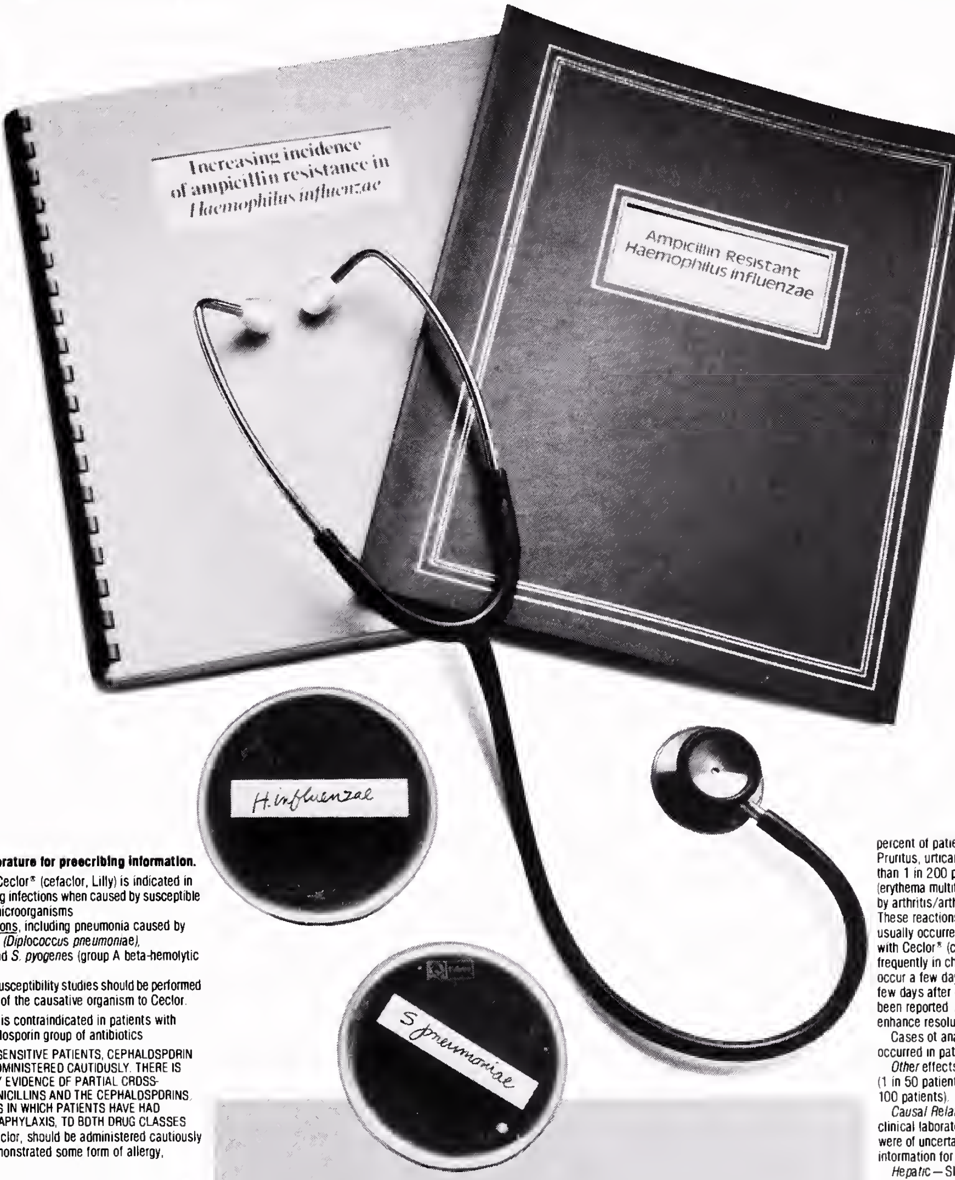
They say, well, what'd you do for me in Washington? Well, what we did for you in Washington is we don't have National Health Insurance. We don't have mandatory acceptance of assignments under Medicare. We didn't have, out of the Carter Administration, mandatory caps on hospitals. We have not yet had any mandatory process that came out of the Congress of the United States in the last seven years that would have radically altered the way you practice medicine.

You can start there. But, half of this profession is not helping do that.

We at the AMA believe that a strong and viable membership base is absolutely essential in this moment in history if we're able to protect this profession at all, and the people it serves. When we talk about protecting the profession what we're really talking about is protecting the people that the profession serves. Nobody else is going to protect them.

Doctor Sammons is executive vice president of the AMA.

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

References

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5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C. American Society for Microbiology, 1978
6. Antimicrob. Agents Chemother., *13*:861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487 New York John Wiley & Sons, 1979

Lilly

Additional information available to the profession on request from
Eli Lilly and Company.
Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

200066

MSMS committees carry on the work of the society

Committee on Aging

This Committee examines the status of senior citizens and advocates good health, preventive medicine programs, and adequate care for those who survive longer because of advances in medicine. It strives to revitalize local committees on aging.

William T. Bateman, MD, Chairman, Kalamazoo
Harvey M. Andre, MD, Kalamazoo
Kimberly A. Brown, WSU
Russell Holmes, MD, Lansing
Patricia M. Perry, U-M
Timothy J. Tobolic, MD, Byron Center
Kevin A. Kelly, Staff Assistant

Task Force on Ambulatory Facilities

This Task Force collects data and proposes policy concerning the financing of ambulatory facilities. It also studies how these facilities affect physicians.

Peter A. Duhamel, MD, Chairman, Rochester
Gilbert B. Bluhm, MD, Southfield
Frank E. Check, Jr., MD, Detroit
Richard P. Horsch, MD, Farmington
Max L. Lichter, MD, Melvindale
Edwin H. Gullekson, MD, Flint
Kenneth J. Ray, MD, Trenton
Floyd S. Tukel, MD, Dearborn
John A. Richards, Staff Assistant

Planning Committee for MSMS Annual Scientific Meeting

This Planning Committee, under the guidance of the Committee on CME Programming, plans and presents Category I Credit courses at the Annual Scientific Meeting. It provides CME courses of value to all specialties while striving to improve methods of education and evaluation.

Frank Cox, Jr., MD, Chairman, Detroit
Denis F.Cash, MD, Flint
Edward Cotton, MD, Marcellus
Julian T. Hoff, MD, Ann Arbor
Kenneth L. Krabbenhoft, MD, Detroit
David R. Rovner, MD, East Lansing
Joan C. Stryker, MD, Detroit
Herbert A. Auer, Consultant, East Lansing
Sherry L. Fent, Staff Assistant

Steering Committee on Program to Assist Impaired Physicians

The Steering Committee provides assistance to physicians who have problems related to emotional illness, alcoholism, or drug abuse. Education toward prevention, case finding, and intervention are major components of the program.

Carl A. Gagliardi, MD, Chairman, Dearborn
Margaret Gregory, MSU
Robert H. Hydrick, MD, Grand Rapids
Joyce W. Mason, MD, Ann Arbor
Stephen C. Mason, III, MD, Ann Arbor
Ward M. Smathers, MD, Lathrup Village
Justin L. Sleight, MD, Lansing
Russell F. Smith, MD, Whitmore Lake
Katie Brewbaker, Staff Assistant

Committee on Awards

This Committee supervises the MSMS award program and makes recommendations to The Council.

Justin L. Sleight, MD, Chairman, Lansing
Robert M. Leitch, MD, Battle Creek
Frank B. Walker, MD, Grosse Pte. Farms
Katie Brewbaker, Staff Assistant

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Richard M. Campau, Staff Assistant

Advisory Committee to Bureau of Economics

The Advisory Committee assists the Bureau in setting priorities, studies current health care financing, makes specific recommendations concerning future financing mechanisms, and develops an understanding of traditional insurance companies, emerging alternative financing, and health delivery systems.

Jay K. Harness, MD, Chairman, Chelsea
Jack L. Barry, MD, Saginaw
Gilbert B. Bluhm, MD, Southfield
Frederick B. Brown, MD, Muskegon
John B. Bryan, MD, Royal Oak
Robert B. Carbeck, MD, Ann Arbor
Dean P. Carron, MD, Ann Arbor
Frank E. Check, Jr., MD, Detroit

James D. Fryfogle, MD, Southfield
Robert H. Hamburg, MD, Detroit
Hector J. Inchaustegui, MD, Royal Oak
Margaret E. Jones, MD, East Lansing
Henry A. Kallet, MD, Ann Arbor
Max L. Lichter, MD, Melvindale
John P. Papp, MD, Grand Rapids
Beverly C. Payne, MD, Ann Arbor
Richard L. Rapport, MD, Flint
Floyd S. Tukel, MD, Dearborn
Allen F. Turcke, MD, Flint
Frederick W. VanDuyne, MD, Flint
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Malcolm Hatfield, MSU
Mrs. Barbara Grennan, Muskegon
Richard A. Quinones, U-M
Mark R. Traill, MSU
Mark B. VandenBosch, U-M
John A. Richards, Staff Assistant

Committee on Claims Form and Uniform Code

This Committee monitors the development and implementation of the uniform claims form and coding system for third party payors in Michigan. It represents MSMS in working toward conversion to the national claims processing system mandated by federal law, and facilitates the implementation of new procedure codes approved by specialty societies.

John B. Bryan, MD, Chairman, Royal Oak
Frederick W. Bryant, MD, Royal Oak
John A. Richards, Staff Assistant

Committee on Concerns of Women Physicians

This Committee will plan a second annual conference for women physicians and explore other ways to encourage the participation and leadership involvement of women physicians in organized medicine.

Miriam S. Daly, MD, Chairman, Albion
Anna M. Broecker, MD, Grand Rapids
Frederick W. Bryant, MD, Royal Oak
Sherry Clark, MD, Midland
Vivian M. Lewis, MD, Flint
Linda J. Logsdon, MD, Southfield
Robert E. Paxton, MD, Fremont
Marguerite Shearer, MD, Dexter
Robert J. Toteff, MD, Detroit
W. Donald Weston, MD, East Lansing
Sherry L. Fent, Staff Assistant

Committee on Constitution and Bylaws

This standing Committee reviews proposals to amend the MSMS Constitution and Bylaws and presents recommendations for appropriate action by the MSMS House of Delegates. It serves as a reference committee during the House of Delegates meeting.

Earl G. Moehn, MD, Chairman, Mt. Clemens
John F. Fennessey, MD, Grosse Pte.
John W. Hall, MD, Petoskey
Thomas F. Higby, MD, Fowlerville
James E. McGillicuddy, MD, Lansing
John H. McLaughlin, MD, Birmingham
B. David Wilson, MD, Kalamazoo
A. Stewart Kerr, Consultant, Detroit
Warren F. Tryloff, Consultant, East Lansing
Vada L. Davis, Staff Assistant

Committee on Continuing Medical Education Accreditation

This Committee maintains standards to assure that quality CME activities are available to Michigan physicians, through review, evaluation, and accreditation of continuing medical education providers in the state.

Donald J. Aiken, MD, Chairman, Okemos
Richard F. Willis, MD, Vice Chairman, Alpena
Philip Adler, DO, Farmington Hills
Gail I. Bank, PhD, Detroit
James C. Breneman, MD, Galesburg
Laurence Bruggers, MD, Saginaw
Allen D. Damschroeder, MD, Petoskey
Alfred Ellison, MD, Lansing
Roland G. Hiss, MD, Ann Arbor
Nathan Kaufman, WSU
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Richard W. Pomeroy, MD, Okemos
Michael Radke, PhD, Lansing
Robert K. Richards, PhD, Grand Rapids
Joseph A. Sentkeresty, MD, Grand Rapids
Robert L. Tupper, MD, Grand Rapids
W. Donald Weston, MD, East Lansing
Charles L. Zeller, MD, Kalamazoo
Vada L. Davis, Staff Assistant

Committee on Continuing Medical Education Programming

The Committee develops, conducts, and supervises Category I programs in Michigan to serve the continuing medical education needs and interests of physicians. It also is empowered to co-sponsor programs which meet the criteria for Category I programs.

Samuel M. McMahon, MD, Chairman, Lansing
John R. Addy, MD, Lansing
Frederick W. Bryant, MD, Royal Oak
Merle A. Childers, MD, Rochester
Edward Cotton, MD, Marcellus
Frank Cox, Jr., MD, Detroit
Clyde R. Flory, Jr., MD, Lansing
Stephen P. D'Addario, WSU
Edward L. Harwell, MD, Bad Axe
Gerald B. Holzman, MD, East Lansing
Mary J. Kokosky, MD, Dearborn
Daniel E. Leb, MD, Pontiac
Richard A. Lemmer, MD, Kalamazoo
Mark W. Schaar, MSU
Joan C. Stryker, MD, Detroit
David B. Youel, MD, Ann Arbor
Herbert A. Auer, Consultant, East Lansing
Sherry L. Fent, Staff Assistant

Liaison Committee with Corporate Medical Directors

This Liaison Committee will meet with medical directors of corporations to discuss common interests. It will recommend appropriate courses of action to The Council.

Thomas C. Payne, MD, Chairman, East Lansing
(Members to be appointed)
William E. Madigan, Staff Assistant

Committee on Federal Legislation and Related Matters

This one-man Committee works in cooperation with the Washington, DC, office of the American Medical Association.

Richard J. McMurray, MD, Chairman, Flint
Bruce W. Ambrose, Staff Assistant

Steering Committee on Health Planning

This Committee recommends MSMS policy on health planning. It encourages physician involvement in health planning issues, monitors activities of health systems agencies (HSA) and the Statewide Health Coordinating Council (SHCC) and assures physician input.

Kenneth J. Ray, MD, Chairman, Trenton
Sanjay Bhansali, WSU
Billy B. Baumann, MD, Pontiac
James D. Fryfogle, MD, Southfield
George R. Gerber, MD, Rochester
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Susan Howard, U-M
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Charles L. Seifert, MD, Battle Creek
Lewis E. Simoni, MD, Flint
Robert J. Toteff, MD, Detroit
Robert L. Tupper, MD, Grand Rapids
Theodore S. Vanderveen, MD, Grand Haven
Roger W. Mecum, Advisor, Detroit
Hermann A. Ziel, Jr., MD, Consultant, Lansing
Dennis M. Paradis, Staff Assistant

Committee on Humanitarian Services

This Committee identifies areas where MSMS may use its influence at the state, national, or international level to improve the public's health and increase the awareness of MSMS membership about current humanitarian services involving members of organized medicine.

James H. Tisdel, MD, Chairman, Port Huron
Fleming A. Barbour, MD, Flint
Mrs. Cheri Calvelo, Jackson
Mrs. Betty Drew, Bloomfield Hills
Brooker L. Masters, MD, Fremont
John R. Ylvisaker, MD, Bloomfield Hills
Dennis M. Paradis, Staff Assistant

Task Force to Improve Component Society Relations

This Task Force seeks to improve working, cooperative relationships with components, their officers and executives, by encouraging or developing visitation programs, by involvement in special seminars or through special program segments of the MSMS Public Affairs Leadership Conference. It also determines components' needs and makes recommendations to The Council for fulfilling those needs.

James H. Tisdel, MD, Chairman, Port Huron
Vickers C. Hansen, MD, Manistee

Charles L. Oppy, MD, Roscommon
Robert J. Toteff, MD, Detroit
William E. Madigan, Staff Assistant

Judicial Commission

The Commission has sole jurisdiction over matters of ethics, mediation, grievance, and discipline of MSMS members. It has authority to make binding interpretations of the MSMS Constitution and Bylaws and of component society bylaws, as well as rules and regulations governing such matters.

(Chairman will be elected in early February)
(Commissioner from District 5 to be elected)
Edwin R. Guise, MD, Detroit
Raymond C. Husband, MD, Detroit
Charles N. Inniss, MD, Detroit
Adam C. McClay, MD, Traverse City
John H. McLaughlin, MD, Birmingham
Richard J. McMurray, MD, Flint
Joseph L. Ponka, MD, Detroit
John C. Reinstra, MD, Grand Rapids
George D. Stilwill, MD, Lansing
A. Stewart Kerr, Consultant, Detroit
Vada L. Davis, Staff Assistant

Liaison Committee with Auxiliary

The Liaison Committee advises the MSMS Auxiliary, on request, regarding Auxiliary activities and problems. It also suggests projects the Auxiliary may wish to undertake.

R. Jack Chase, MD, Chairman, Grand Rapids
Dean P. Carron, MD, Ann Arbor
Lawrence E. Grennan, MD, Muskegon
John R. Ylvisaker, MD, Bloomfield Hills
Fikria B. Hassan, MD, Advisor, Flint
Caraline A. Rich, Staff Assistant

Liaison Committee with Medical Assistants

The Liaison Committee advises the American Association of Medical Assistants, State of Michigan, on request, regarding medical assistant activities and problems. It also suggests projects the medical assistants may wish to undertake.

David W. Hills, MD, Chairman, St. Joseph
Donald L. Baltz, MD, Dearborn
Darwin J. Beldon, MD, Detroit
Harold H. Niekamp, MD, Jackson
James R. Quinn, MD, Pontiac
Joseph J. Tiziani, MD, Ann Arbor
Caraline A. Rich, Staff Assistant

Liaison Committee with Michigan Department of Public Health

The Committee works to improve information and communication channels among public health officers, practicing physicians, and the public on public and environmental health issues of mutual concern.

E. Joseph Alberding, MD, Chairman, Portage
Fred H. Ayers, MD, Daggett
Cathy O. Blight, MD, Flint
Henry M. Domzalski, MD, Detroit
David S. Nolen, MD, Detroit
Francis L. Purcell, MD, Ypsilanti
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Lucius C. Tripp, MD, Warren
Norman L. Welch, MD, Muskegon
Bailus Walker, PhD, MDPH Director
James Harrison, MD, MDPH Chief Medical Officer
Sherry N. Wellman, Staff Assistant

Committee on Maternal and Perinatal Health

This Committee strives to improve the care of the obstetrical patient and her newborn and to provide means for physicians, nurses, and others interested in maternal and perinatal health to discuss mutual problems and share ideas. It works in close cooperation with state agencies and medical specialty organizations.

Hermann A. Ziel, Jr., MD, Chairman, Lansing
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Mrs. Pat Krapohl, Jackson
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Daniel J. Wilhelm, MD, Port Huron
Joseph J. Woods, MD, Southfield
William G. Anderson, II, DO, Consultant, Detroit
Mason Barr, Jr., MD, Consultant, Ann Arbor
Ronald E. Brooker, DO, Consultant, Livonia
Jean Chabut, MDPH Consultant, Lansing
Eugene V. Perrin, MD, Consultant, Detroit
Philip J. Howard, MD, Consultant, Detroit
Honorary Members:
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James E. Harryman, MD, Muskegon
Francis A. Jones, MD, Vero Beach, FL
Norman F. Miller, MD, Florence, WI
Charles S. Stevenson, MD, Center Sandwich, NH
Helen A. Schulte, DeWitt
Katie Brewbaker, Staff Assistant

Medicaid Liaison Committee

The Liaison Committee attempts to resolve individual physicians' problems with Medicaid payments and procedures, and discusses major policy issues of the Medicaid program with state government.

Allen F. Turcke, MD, Chairman, Flint
John W. Coles, MD, Mt. Pleasant
Thomas M. Flake, MD, Southfield
James D. Johnston, MD, Traverse City
Cecil R. Jonas, MD, Detroit
Henry A. Kallet, MD, Ann Arbor
Gerald H. Mandell, MD, Detroit
Robert J. Toteff, MD, Detroit
Sherry N. Wellman, Staff Assistant

Task Force on Medical Care Costs

The Task Force considers and evaluates methodologies for containing the cost of quality health care, encourages cost awareness, and develops cost effectiveness information for the practicing physician. It interfaces with the BCBSM Regional Cost Committees, acts as a liaison committee to physicians serving on these committees and reviews cost containment initiatives by the RCCs. The Task Force also publishes articles on cost containment in *Michigan Medicine*.

R. Jack Chase, MD, Chairman, Grand Rapids
Everette Gustafson, MD, Pontiac
Lisa Hacker, U-M
Richard P. Horsch, MD, Farmington
James E. McGillicuddy, MD, Lansing
William J. Rice, MD, St. Clair Shores
B. David Wilson, MD, Kalamazoo
Debarah Zannath, Staff Assistant

Task Force on Medical Fraud and Abuse

The Task Force strives to assist the State of Michigan and third party payors in developing programs to counter illegal or unethical activities in the health care system. It also identifies areas of the medical system where there is a high potential for abuse and recommends possible methods of prevention.

Continued on page 692

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OSTEOMALACIA
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Contact:

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Medical Education
Henry Ford Hospital
(313) 876-1464

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Robert H. Hamburg, MD, Detroit
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Robert A. Lozano, MSU
Richard L. Rapport, MD, Flint
John A. Richards, Staff Assistant

Committee on Medical Staff Relations

This Committee is working to develop a specific mechanism for interacting with hospital medical staffs and to strengthen and enhance the mutual communications of MSMS and its medical staff leader members.

Gary D. Maynard, MD, Chairman, Kalamazoo
Robert D. Allaben, MD, Detroit
Robert W. Black, MD, Detroit
Dane M. Chapman, U-M
James J. Humes, MD, Detroit
John C. Sullivan, MD, Port Huron
Leonard H. Wolin, MD, Ann Arbor
William E. Madigan, Staff Assistant

Committee on Membership Recruitment and Retention

This Committee guides all recruitment efforts aimed at non-member physicians, residents, and students. It develops membership goals, makes recommendations to The Council and conducts personal recruiting efforts when needed.

Billy B. Baumann, MD, Chairman, Pontiac
David M. Alessi, WSU
Harry D. Allis, MD, Lansing
Cathy O. Blight, MD, Flint
Dale R. Drew, MD, Pontiac
Myrtle S. McLain, MD, Grand Rapids
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John M. Murphy, MD, Port Huron
Pamela Papas, WSU
Tom Prosé, WSU
John W. Tauscher, MD, Flint
Louis R. Zako, MD, Dearborn Heights
Mr. Norman Anderson, Advisor
Mrs. Nelda Gasperson, Advisor
Ms. Sue Hoeflinger, Advisor
Mr. Robert F. Mecum, Advisor
Mrs. Mary Sue Meyer, Advisor
Merwyn G. Scholten, Staff Assistant

Planning Committee for 1983 Michigan Conference on Maternal and Perinatal Health

The Planning Committee, under the guidance of the MSMS Committee on Maternal and Perinatal Health, plans and implements a Category I CME program for the Annual Michigan Conference on Maternal and Perinatal Health, in cooperation with several participating organizations.

Gerald B. Holzman, MD, Co-chairman, East Lansing
Kenneth J. VanderKolk, MD, Co-chairman, Grand Rapids
John R. Addy, MD, Lansing
Rudi Ansbacher, MD, Ann Arbor
C. Arch Brown, MD, Flint
Laurence Bruggers, MD, Saginaw
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Mary A. Scoblic, RN, Lansing
Hermann A. Ziel, Jr., MD, ex officio
Katie Brewbaker, Staff Assistant

Michigan State Medical Society/Michigan Hospital Association Liaison Committee

This formal Liaison Committee is composed of designated leaders of the two organizations. The Liaison Committee does not make policy for either organization; each organization refers any recommendations to the MSMS Council or MHA Board of Trustees for approval.

Thomas R. Berglund, MD, Chairman of The Council, Portage
Donald K. Crandall, MD, President-elect, Muskegon
James D. Fryfogle, MD, Immediate Past-president, Southfield
James H. Tisdel, MD, President, Port Huron
Warren F. Tryloff, Director, East Lansing
William E. Madigan, Staff Assistant

Committee on MSMS Policy Manual

This Committee reviews actions of the House of Delegates and incorporates any policy decisions made into the Policy Manual of MSMS.

Robert D. Burton, MD, Chairman, Grand Rapids
Frederick W. Bryant, MD, Royal Oak
Leland E. Holly, II, MD, Muskegon
Richard L. Rapport, MD, Flint
Kenneth J. Ray, MD, Trenton
Vada L. Davis, Staff Assistant

Task Force on Professional Liability

The Task Force reviews the professional liability climate in Michigan and the nation, becomes familiar with the professional liability terms and legislation, and recommends any appropriate legislation or alternative mechanisms to be used in Michigan. ,

Frederick V. Minkow, MD, Chairman, Bloomfield Hills
Billy B. Baumann, MD, Pontiac
Thomas C. Payne, MD, East Lansing
Rhoda M. Powsner, MD, Ann Arbor
Kenneth J. Ray, MD, Trenton
James A. Read, MD, Birmingham
John L. Shek, MD, Saginaw
Donald N. Sweeny, Jr., MD, East Detroit
William B. Cheeseman, Consultant, East Lansing
William E. Madigan, Staff Assistant

Committee on Publications

This Committee serves as an advisory board to the editor in determining policy, setting new directions, suggesting subject material, overseeing finances, and reviewing all display advertising for MSMS publications.

Busharat Ahmad, MD, Chairman, Marquette
Harvey M. Andre, MD, Grand Rapids
James D. Fryfogle, MD, Southfield
Vickers C. Hansen, MD, Manistee
Charles L. Oppy, MD, Roscommon
James H. Tisdel, MD, Port Huron
Judith Marr, Staff Assistant

Committee on Public Service

This Committee develops and oversees all public relations and public information activities. It provides physician input to the program suggestions and activities advanced by outside consultants and MSMS staff.

Richard H. Gascoigne, MD, Chairman, Adrian
Mrs. Cheri Calvelo, Jackson
Mark G. Campbell, MD, Grand Rapids
Dean P. Carron, MD, Ann Arbor
William T. Cook, U-M
Robert L. Cross, MD, Flushing
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William K. Howard, MD, Detroit
John H. Libcke, MD, Pontiac
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Thomas C. Payne, MD, East Lansing
Marsha M. Rohrer, MD, Lansing
Richard R. Royer, MD, Detroit
Mr. Norman Anderson, Advisor
Merwyn G. Scholten, Staff Assistant

Task Force to Develop Quality Assurance Proposal

This Task Force coordinates the activities of the Physician's Review Organization of Michigan (PROM) and makes recommendations to The Council.

Gerald H. Mandell, MD, Chairman, Detroit
Charles R. Aldridge, MD, Grand Rapids
John B. Bryan, MD, Royal Oak
William D. Carpenter, MD, Southfield
Henry M. Domzalski, MD, Detroit
George F. Newman, MD, Ypsilanti
Robert C. Packer, MD, Muskegon
Frederick W. VanDuyne, MD, Flint
William F. Weston, MD, Kalamazoo

Task Force on Rate Regulation

This Task Force responds to and anticipates state activities involving rate regulation.

Robert D. Allaben, MD, Chairman, Detroit
Gilbert B. Bluhm, MD, Detroit

Continued on page 694

Billing Department:

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Rhoda M. Powsner, MD, Ann Arbor
Jack Ryan, MD, Detroit
Donald C. Smith, MD, Farmington Hills
Floyd S. Tukel, MD, Dearborn
Bruce W. Ambrose, Staff Assistant

Committee on Risk Management Program

This Committee aids in the development of any risk management program or courses which MSMS decides to offer to its members through its own resources or those of the Physician Service Group, Inc.

Louis R. Zako, MD, Chairman, Dearborn Heights
Leland E. Holly, II, MD, Muskegon
Robert M. Leitch, MD, Battle Creek
W. Peter McCabe, MD, Grosse Pte. Woods
Marguerite Shearer, MD, Dexter
J. Douglas Peters, Consultant, Detroit
William E. Madigan, Staff Assistant

Task Force to Study Role of Insurance Commissioner and Methods used by BCBSM to Establish its Rates

This Task Force will study the Blue Cross Blue Shield of Michigan method of establishing its rates and prepare a report on its findings for The Council.

Marion G. McCall, Jr., MD, Chairman, Detroit
William B. Jensen, Jr., MD, Grand Rapids
Arthur A. Ulmer, MD, Grosse Pte. Shores
John A. Richards, Staff Assistant

Committee of Specialty Society Presidents

This Committee provides for rapid communication between MSMS and the members of specialty organizations. It deals with any subject of mutual concern except scientific or clinical medicine.

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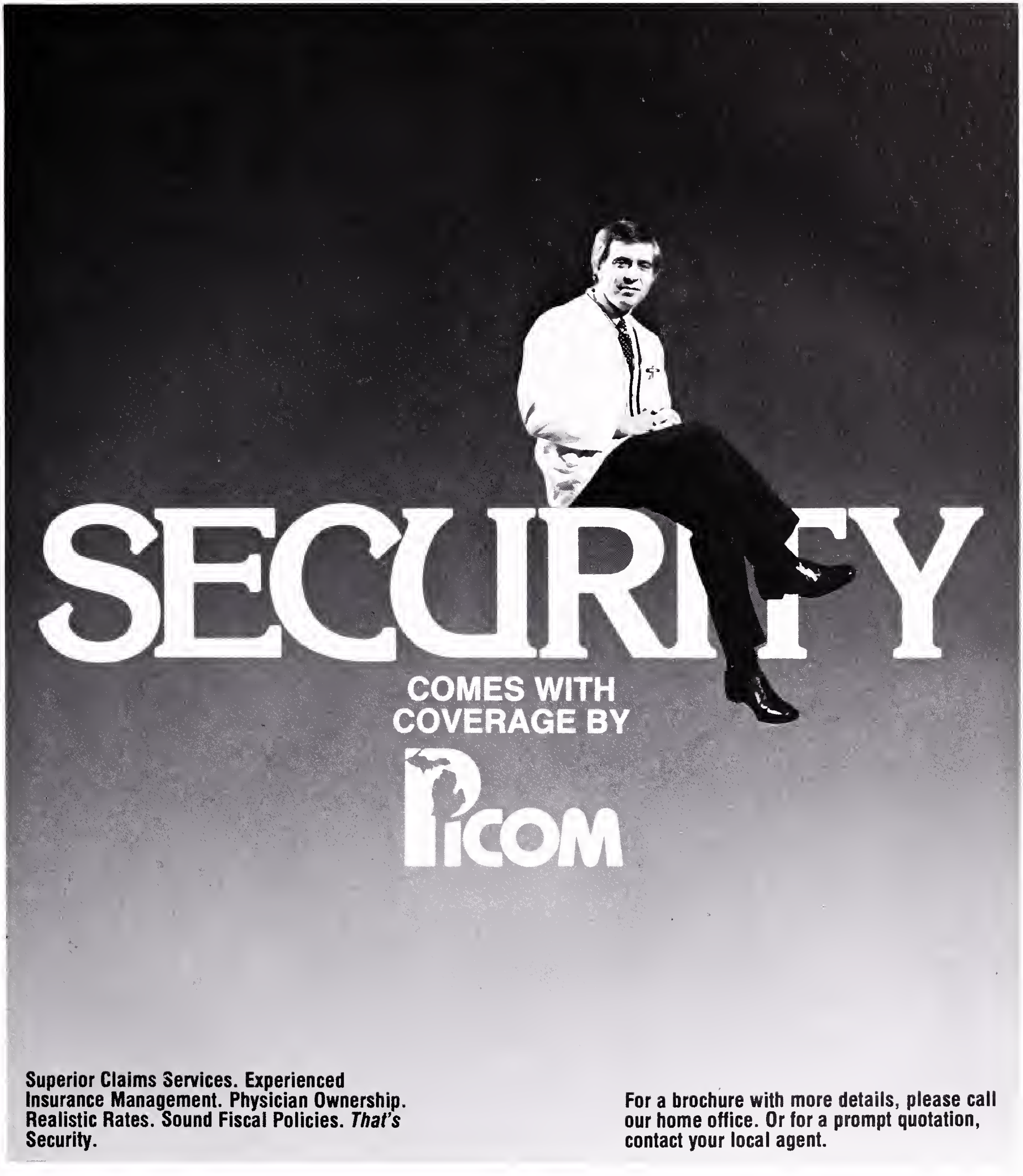

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Recent cases of note

MSMS Legal Counsel A. Stewart Kerr contributes the following notes on current legal cases of importance to MSMS members.

Staff privileges

A federal court in Pennsylvania has knocked out an antitrust suit against a hospital based upon denial of staff privileges to certain physicians. Basically, the physicians' claim of treating patients who travel in interstate commerce did not satisfy the interstate commerce jurisdictional requirement. The physicians also failed in the allegations that the denial of staff privileges violated their Fourteenth Amendment rights, allegedly depriving them of a constitutionally protected property interest.

Hospital contract

The Federal Court of Appeals at New Orleans recently held that a hospital's exclusive contract with a P.C. for anesthesia services is a per se, unlawful, tying arrangement — a violation of the antitrust laws. The fact that the contract was a tying arrangement was not seriously disputed. The legal question was the relevant geographic market. The Court held that nearly one-third of the patients in the particular area went to that hospital; the hospital was limited by state law to serving a single parish, hence the parish was the relevant geographic market for tying analysis.

This case was brought by an anesthesiologist who was favorably recommended by the medical staff but was denied hospital privileges because of the exclusive contract.

Exclusive hospital services contracts have been upheld elsewhere. This decision hinged in part upon the peculiarity of the parish market limitation but the case must be kept in mind by hospitals and staffers, particularly if it should get to the Supreme Court.

Board of Medicine issues word on illegal Rx for family

The following policy statement by the Michigan Board of Medicine was adopted October 13, 1982. The statement deals with prescribing habits of physicians, particularly with respect to themselves or members of their family. During the past year there have been a number of cases in which physicians have prescribed for themselves or for members of their family or close relatives or for the wives of other physicians in a manner outside the normal scope of their medical practice. A number of these matters have come to the attention of the Michigan Board of Medicine and have resulted in sanctions against the physicians. The policy statement is an attempt by the Michigan Board of Medicine to address this problem, to warn physicians of the risk involved in such prescribing practices.

POLICY STATEMENT
Michigan Board of Medicine

The Michigan Board of Medicine has recently disciplined physicians who improperly prescribed controlled substances for family members. The cases serve to emphasize that a physician may risk disciplinary action, including revocation of his/her license to practice medicine, when attempting to treat a family member with the use of controlled substances.

Once entered into by the physician, a patient/family member relationship becomes increasingly difficult to manage from a professional standpoint. The small inconvenience to a family member which may occur when a physician refers that family member to a professional colleague must be balanced against the severe harm that can be inflicted upon the patient because of a loss of professional judgment in a dual relationship.

The dual relationship created by a family member patient can cause a loss of professional objectivity which results in serious consequences both for the patient and the physician. The negligent or intentional abuse of controlled substances is no less a tragedy because the physician did not know how to say "no" to his/her spouse or a member of the family. Unfortunately, symptoms of substance abuse which the physician easily recognizes in a non-family member may be harder to see when a family member patient asks for another prescription.

In summary, a physician who takes it upon him/herself to be the physician for a family member runs a considerable risk of compromising professional judgment which may subject that same well-intentioned but ill-advised physician to disciplinary action by this licensing board.

Disciplinary action

The following actions of the Michigan Board of Medicine were taken following investigation and appropriate administrative action and are summarized below by MSMS legal counsel from official memoranda to MSMS.

- **Carol R.D. Varner**
2248 E. Mt. Hope
Okemos 48864

Date, action taken

Sept. 11, 1982

License revoked, effective November 10, 1982

Violation

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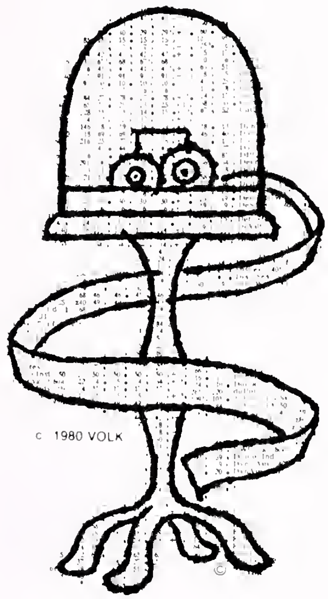
By Daniel Ludwin
East Lansing



What investment can you think of that will accumulate tax free, allow you to withdraw tax free, and then pass the investment to your heirs free of tax? It has characteristics of a municipal bond, a deferred annuity, and a money market fund.

Give up? It's a life insurance contract called single-premium or one-payment whole-life. Like the deferred annuity it remained dormant for many years and was seldom sold.

Mr. Ludwin is senior vice president of Prescott, Ball and Turben, investment bankers and brokers, East Lansing. He is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve funds assets. He has 15 years' experience in the financial field.

Most life insurance policies require an annual payment throughout your lifetime with the death benefit far exceeding the premium you pay. With a single-premium policy, the death benefit is much closer to the amount paid since the entire premium is included in one payment.

In the past, none of this was very exciting as traditional life insurance policies could only return four to five percent on your cash value.

Then, in 1978, a company called Keystone Provident Life Insurance Company of Boston, Massachusetts started a search for a desirable investment. They set up strict criteria. It had to be safe, have a 100 percent daily guarantee of principal, provide competitive interest earnings, be highly liquid, and completely free of income tax. They also wanted to make it flexible enough either to accumulate, compound or provide an annual tax-free cash flow.

Surprisingly, the idea for the new product was found in the pages of the tax code that covers the tax treatment of life-insurance contracts.

The people at Keystone Provident Life designed this new concept built around a single-premium life insurance policy. Let's take a closer look at what it does, how it works, and who should consider buying it.

I'm going to ask some questions you probably would like answered before you invest your money.

Q. I like everything you've told me, but what do the numbers look like?

A. Here is an illustration from Keystone Provident (there are at least two other excellent companies marketing this product now: National Investor's with Lifeplan and Charter National's TAPLAN. All three products are similar).

First, we'll assume you are a male, 55, with $100,000 to invest. (As little as $10,000 can be invested.) The first illustration shows the effect of accumulating at 11.25 percent, the surrender value and the projected death benefit. The second illustration will show your accumulating cash value, tax-free cash flow of $11,250 (11.25 percent of $100,000) and the death benefit. Look at the illustrations first, and then we'll ask some other questions.

Q. I understand the accumulation of 11.25 percent per year in **Illustration #1**, but why is it not taxed?

A. Because this is a life insurance policy, and cash value increases are not taxed.

Q. In **Illustration #2** you show a cash flow of $11,250 per year — what is this?

A. These are annual loans made from the policy. Policy loans are not taxable income, and in this policy, the loan interest is "washed" by guaranteed interest on the borrowed funds. Meaning the loans cost you nothing.

Q. You mean I can put up $100,000, draw out all the earnings as loans and pay no taxes?

A. Precisely.

Q. What if I die — do the loans have to be repaid?

A. No, they are considered an "advance" on the death benefit. The death benefit minus the loans is received by your beneficiary tax free.

Q. How long is the interest rate guaranteed?

A. Usually for one year. They offer a "bail-out" rate after the first year which would be one percent below the rate you came in at. This means you'll pay no surrender charges if the rate would fall below that bailout rate. If you surrender the policy under any other circumstances, there is a declining surrender charge for the first ten (10) years.

Q. This sounds great, but why is this considered a life insurance policy?

A. Because it has a premium, a death benefit at risk (actually a small one, but nevertheless a death benefit), and is payable to a named beneficiary as a result of the death of the insured.

Q. Is there a catch?

A. Not really, but if you surrender the policy your gains will be taxed as ordinary income much like a deferred annuity — and that's still good.

Q. But, if I just continue to make loans I'll never pay taxes?

A. Exactly. And neither will your beneficiary.

Q. Who should consider investing in this policy?

A. Those people in a high income-tax bracket nearing retirement who want to put their money in something safe and secure.

Illustration 1
KEYPLAN ILLUSTRATION

Single Premium: $100,000 **Male — Age 55**

End of Year	Accumulation of $100,000 @ 11.25% (1)	Projected Surrender Value (2)	Projected Death Benefit (2)
1	$111,250	$104,575	$112,423
2	123,765	116,340	124,632
3	137,689	129,428	138,376
4	153,179	143,989	153,539
5	170,411	160,187	170,453
6	189,583	180,862	192,082
7	210,911	203,951	216,234
8	234,638	229,712	243,066
9	261,035	258,426	273,087
10	290,402	290,402	306,440

Summary

You Pay—$100,000	Should You Die, Your Beneficiary Receives:	
End of Year	Death Benefit to Beneficiary (2)	Income Tax to Beneficiary (2)
10	$306,440	None

The tax effects described above and in Illustration 2 are those accorded life insurance contracts. You should consult your tax advisor or attorney for the specific applications to your situation.

(1) This column is included for illustrative purposes only.

(2) These benefits include projected additional benefits based on the combined rate of 11.25 percent. These additional benefits are not guaranteed.

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Illustration 2
KEYPLAN LOAN ILLUSTRATION

Single Premium: $100,000 Male — Age 55

This illustration is based on annual loan disbursements which must be requested by the owner each year.

End of Year	Projected Cash Value (Before Loan) (1)	Current Loan	Loan Balance Outstanding	Projected Surr. Value (After Loan) (1)	Projected Death Benefit (1)
1	$104,575	$11,250	$11,250	$93,325	$101,173
2	115,518	11,250	22,944	92,574	100,808
3	126,839	11,250	35,101	91,738	100,506
4	138,546	11,250	47,737	90,809	99,998
5	150,648	11,250	60,873	89,775	99,429
6	165,806	11,250	74,527	91,279	101,564
7	181,760	11,250	88,721	93,039	103,986
8	198,548	11,250	103,476	95,072	106,614
9	216,202	11,250	118,813	97,389	109,655
10	234,757	11,250	134,757	100,000	112,963

Summary

You Pay: $100,000

	10th Year
Amount Taken Out (1)	$112,500
Death Benefit (1)	$112,963
Income Tax	None

(1) *These benefits include projected additional benefits based on the current combined rate of 11.25%. These additional benefits are not guaranteed.*

Q. How safe is this product?

A. Well, Keystone Provident Life is rated A+ (Excellent) by Best Reports, and the company is owned by the giant Travelers Corporation. It is as safe as any cash value policy backed by the legal-reserve life insurance system.

Q. Is the policy available in a number of states?

A. Yes, the policy is permitted for sale in most states and has been judged to be a life insurance policy.

Q. What else should I know?

A. Make sure you get all the facts of the particular policy you're considering before you make a decision.

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Business PACs: Do they really sway votes?

By Lloyd N. Unsell
Washington, DC

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Most of the anguish being expressed over business-industrial community participation in the political process is based on an intellectually crippled premise: that only business contributions from political action committees (PACs) are somehow corrupting and are intended to "buy" votes in Congress. This reflects a dismal distrust and misunderstanding of the political system and of politicians.

Ralph Nader and Common Cause have agonized at length about the influence of business PACs. The latter has even found something sinister in correlations between PAC contributions by automobile, medical and dairy interests and the votes of congressmen that affect these interests. The "discovery" that congressmen supported by such groups voted favorably for them is not a scandalous relevation, but only confirms an obvious expectation. Do the Naderites and Common Causers actually believe that business groups should favor their political enemies with campaign contributions? Even more to the point, would Mr. Nader and Common Cause deliberately seek to reelect politicians opposed to their policies? If the answer is "no," why would they expect others to do so?

The naivete in all this, if indeed it could be laid to naivete, stems from the assumption that every member of Congress is elected to vote for and support a composite viewpoint of his constituency — and that the only thing keeping him from it is evil business lobbyists with bags of PAC money. Poppycock. No such congressman has ever existed. I have never known a member of Congress who came to Washington without a well-defined philosophy and who depended on "constituent signals" to decide how to vote. To the contrary, most members of Congress arrive in Washington assuming that, as a result of the election, their philosophies have been ratified by their constituencies.

In the past 25 years, the members who have totally changed their philosophy can be counted on one hand. Most maintain and vote their basic philosophy and are "known quantities" on most issues.

My associates and I have talked to about 400 congressional candidates in the past four national elections. Not once have we given any candidate the "litmus test" on any issue, as some business-industrial PAC critics suspect and suggest. What we have tried to determine is the basic philosophy of candidates with respect to the role of government, tax policy, regulatory policy, spending policy and the like. From a candidate's description of his philosophy, it does not take a PhD in logic to determine how he will generally vote on issues affecting the business-industrial community, including energy producers.

Everyone involved in the political process — and to my mind involvement is a right, duty and obligation — presumably supports politicians for the philosophy they represent. If PAC managers do not do this, they are doing a disservice to those whose funds they are using. This is only a rational expectation that extends to those operating from all shades of the political spectrum. How many of the "new left" PACs, for example, will be supporting Sens. John Tower, Jesse Helms and Steve Symms? If the successful candidates they do pick happen to vote consistent with their philosophy, will this be "bribery?"

Political action committees are nothing more than instruments through which people of like minds can pool their resources and intelligence in support of politicians with whom they agree. In 1976, for example, George Meany's AFL-CIO political legions reportedly contributed $16 million to congressional candidates of primarily leftward persuasion ($10 million cash, $6 million in kind) and Mr. Meany boasted in US News & World Report that the union's COPE organizations were the greatest political force in the world.

I did not hear Common Cause or Ralph Nader condemn George Meany's political arrogance as corrupting. Only when the business-industrial community finally took a page from labor's book and began supporting private enterprise-oriented congressional candidates did the PAC idea become a "corrupting" influence in politics.

A number of pending bills in Congress would revise existing rules to limit political contributions by PACs. The apparent assumption is that reduced contributions would somehow transform "undue influence" into "constructive participation."

The truth is that the continuing attack on business participation in politics has nothing to do with "corruption." Such code words are essential tools of those seeking to discredit business activism in the political process. This tactical smoke screen is directed solely at (a) limiting the political rights of the business-industrial community, in order to (b) restore the political monopoly that big labor and the activist left enjoyed for 40 years.

I cannot imagine a majority in our liberty-minded Congress buying this notion, much less "selling" votes.

Mr. Unsell is executive vice president of the Independent Petroleum Association of America.

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Flint 48502

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Orchard Lake Village 48033

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Livonia 48152

Calls, letters to MSMS reflect public's concerns

By Kim Dean

"Good Morning. Michigan State Medical Society."

"Hello. I have allergies. Can you tell me where I might find ultra violet bulbs for my air purifier?"

As a society which seeks to serve as a liason between the medical profession and Michigan communities, MSMS receives scores of calls from individuals asking assistance. The calls run the gamut from requests for information on an illness or treatment, to referrals of physicians for a special problem, to questions concerning legal matters.

Some of the most common requests MSMS receives reflect the issues making news feature stories or breakthroughs across the nation. The successful births of the "test tube babies" has resulted in increasing calls for information on tubal ligations, artificial insemination, vasectomy reversal, infertility and even surrogate motherhood.

As the health and fitness concern which has swept the country continues, so do the calls regarding bypass surgery for obesity, weight loss clinics and podiatrists. It is interesting to note that a large number of people also are asking for hypnotists and acupuncturists to help with asthma, smoking, overeating and even gynecological examinations and childbirth.

There appears to be great concern within the public and among health care professionals about the law and the effect of the economy on physicians' practices. Common questions involve suits based on omission or failure of adequate informed consent, euthanasia, Patient's Bill of Rights, information of national medical care versus individual responsibility for medical care, and laws regarding professional advertising.

Patients are concerned not only with their rights, but also with their physicians' rights. Many patients want to know what the normal cost of an office visit is while others have more specific concerns such as: "How many doctors are lawyers and how many lawyers are doctors?" or "Is it a law that doctors must remove an appendix when they do abdominal surgery?"

Concern about the environment also reaches the ears of the MSMS staff. One caller wanted to know if heat/radium energy caused cancer, while another caller was worried about radiation fallout and where he could get information on detection equipment.

Many of the calls received at MSMS are standard and can be answered without hesitation.

It is the out-of-the-ordinary calls, however, the prove to be a daily challenge. For example, referral of an "occupressurist" or a "homeopathic" versus a "naturopathic" physician proves to be a difficult task, especially when there is an uncertainty as to what these "specialists" are.

And, in all honesty, "what is the inside story on iridiology (a practice of looking into a patient's eyes in an effort to diagnose various health problems)?" We anxiously await the results of the surveys that wanted to know physicians' opinions of priest faith healers as well as their opinions on coffins!

Calls received at MSMS may be standard or they may be a little out of the ordinary. But whatever their status, people fortunately are using MSMS as a resource to achieve the best medical care possible.

Do you know

**a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?**

If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

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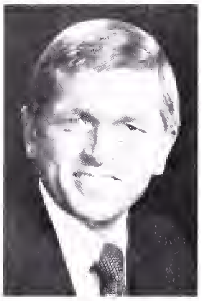
NEWS

By Debbie Lange
East Lansing



Doctor Grabb

Doctor Wilcox

Michael A. Wainstock, MD, clinical associate professor and director of ophthalmic ultrasound, the University of Michigan, was honored by the Department of Engineering for an "outstanding device and patent." The device is an ultrasonic guided gamma probe for intraocular tumor detection. . . . **Alexa Canady, MD,** has joined Henry Ford Hospital as director of pediatric neurosurgery. She comes to HFH from Children's Hospital of Philadelphia where she recently completed a fellowship in her specialty. . . . **William J. Jones, MD, PhD,** was recently elected President of the Civil Aviation Medical Association at the group's 17th annual meeting in Toronto. He has been privately practicing medicine since 1950 in Allen Park, Michigan, where he founded and is presently a Senior Staff Member of the Children's Clinic, P.C.; Chief of Pediatrics at the Oakwood Hospital, Dearborn. . . . **Kenneth R. Wilcox, Jr., MD,** Lansing, Chief of the Laboratory and Epidemiological Services Administration, Michigan Department of Public Health, has been designated State Epidemiologist. . . . **J. Robert Willson, MD,** University of Michigan professor of gynecology and obstetrics, was honored last week by a University of Michigan symposium on a medical specialty he helped establish — care of women in high risk pregnancies and newborn infants. He is currently the Bates Professor of Diseases of Women and Children, and will retire from the University of Michigan Medical School in 1983. . . . The late **William C. Grabb, MD,** past president of the Plastic Surgery Educational Foundation, was awarded the American Society of Plastic and Reconstructive Surgeons Special Achievement Award, posthumously, during the Society's 1982 Annual Scientific Meeting. The award was in recognition of his outstanding contributions to the advancement of plastic surgery and to the cleft lip and palate specialty. . . . **R. Lawrence Kroovand, MD,** assistant professor of urology, has been appointed secretary/treasurer of the Michigan Branch of the American Urological Association. He also was elected executive committee member of the American Academy of Pediatrics and president of the Michigan Myelodysplasia Association. . . . **Roy T. Bergman, DVM, MD,** was selected by the National Federation of Interscholastic Officials to receive a Distinguished Service Award presented to deserving persons outside the field of officiating. In addition, he has been named head physician for the USA 1983 Pan America Games Team and served as head physician for the 1983 Men's Elite Basketball Team at the World Basketball Championship. . . . **Jack F. Sanders, MD,** Alma, was one of 172 persons recognized during the annual session of the Supreme Council of Scottish Rite Freemasonry for the Northern Jurisdiction. Doctor Sanders will receive the thirty-third degree for "outstanding achievement in the fraternity and significant contributions to others reflecting credit on Freemasonry." . . . **Raymond J. Rogers, MD,** was honored for 50 years of practice by the Marinette-Menominee County Medical Societies. . . . **Douglass A. Haddock, MD,** of Kalamazoo, out-going chairman of the Board of Directors of the American Academy of Family Physicians (AAFP), is new vice president of the national family practice organization. Doctor Haddock was elected at the annual meeting of the AAFP's governing body, the Congress of Delegates. . . . **Carl G. King,** retiring executive director of the Saginaw County Medical Society, has been honored with a certificate of a resolution from the SCMS honoring him for his 20 years of service as executive director. He is succeeded by his son, Carl G. King, Jr. . . . **Mary O. Anderson, MD,** was elected to serve on the board of directors of the American Association of Professional Standards Review Organizations (AAPSRO). . . . **Martha Leigh Spencer, MD,** assistant professor in the University of Michigan's Medical School Department of Pediatrics, has been given the Meritorious Award of the American Diabetes Association-Michigan Affiliate at the annual meeting. Doctor Spencer was honored for five years of service on the board of directors and for work since 1976 as medical director of Camp Midicha, a summer camp for diabetic children. . . . At their national convention, the American Association of Medical Assistants elected **Shirley Licking, CMA,** (immediate past Michigan president) as national trustee from Michigan, **Sheila Basilisco, CMA,** (Michigan president-elect) to the Nominating Committee, and **Frankie Jones, MT CMA-AC,** Michigan, to the Certifying Board. . . . Lansing physician **Frederick C. Swartz, MD,** has been recognized by the staff, residents, and patients of the Burcham Hills Retirement Center. Eighty-year-old Doctor Swartz has served as the first and only medical doctor director of the retirement center since it opened in 1974. . . . Several MSMS members are being featured in the new documentary film "Foreign Medical Graduates in the United States." **Yvan Jose Silva, MD,** is interviewer/moderator; **Charles C. Vincent, MD,** is featured as chairman of the Admissions Committee of a major U.S. medical school; **Vimal P. Puri, MD,** as first woman certified by the American Board of Emergency Medicine; and **Augustin Arbulu, MD** and **Ingida Asfaw, MD,** as cardiac surgeons. . . . Long-time MSMS member **Alexander Blain, III, MD,** has published a book called *Clackshant and other Poems.* His book is available from Sylvan Publications, 42185 Baintree Circle, Northville. Doctor Blaim is a Wayne County surgeon.

Statement of ownership, management and circulation

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management, and Circulation of *Michigan Medicine*, published five times per month, 60 issues, mailed at East Lansing, Michigan and additional post offices in Ingham County for December 1, 1982.

1. The office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan, 48823.
2. The general business office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.
3. The publisher is the Michigan State Medical Society. The editor is Judith E. Marr, 120 West Saginaw Street, East Lansing, Michigan 48823.
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6. A. The total number of copies printed averages 9,187 per issue with a single issue nearest to filing date accounting for 9,098 copies.

   B. Paid circulation 8,796 subscriptions by mail, these being the active members of the Michigan State Medical Society, and others who receive subscriptions.

   C. Sales to dealers, number none.

   D. Free distribution by mail carrier or other means: 262.

   E. Total number of copies distributed is 9,058.

I certify that the statements made by me above are correct and complete.

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CATEGORY I COURSES

Michigan Medicine **each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.

Date: Dec. 27-31, Clinical Medicine Update II: An Educational Retreat. Location: San Diego. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education. **For:** Clinicians in internal medicine, family practice, general practice, general surgery, pediatrics, and obstetrics and gynecology. **Cost:** $325. **Contact:** Office of CME, Towsley Center for CME, U-M Medical School, Box 057, Ann Arbor 48109 (313) 763-1400. **Approved for:** 18 hours of Category I Credit.

Date: January 17-20, Current Cardiovascular Therapeutics — 1983. Location: Boyne Mountain Ski Lodge. **Sponsor:** Michigan Heart Association. **Cost:** $75. After January 4, $80. **Contact:** Eleanor D. Peterson, RN, Michigan Heart Association, 16310 West Twelve Mile Rd., PO Box 160-LV, Lathrup Village, 48076. **Approved for:** 14 hours of Category I Credit.

Date: January 19, Rheumatology Day II. Location: Saint John Hospital, 22101 Moross Rd., Detroit, 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Internal Medicine. **Cost:** Saint John Hospital Staff, $75; River District Hospital Staff, $75; Other Physicians, $100. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: Jan. 22-29, Aspen Conference on Emergencies in Medicine. Location: Aspen Conference Center, Aspen, Colorado. **Sponsor:** WSU Department of Surgery. **Contact:** Theresa Sokol, Department of Surgery, WSU, 6-C University Health Center, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 27.5 hours of Category I Credit.

Date: Jan. 30-Feb. 4, Seventh Annual Midwinter Family Practice Update. Location: Boyne Highlands, Harbor Springs. **Sponsor:** Office of CME, U-M Medical School. **For:** Family practitioners. **Cost:** $335 - practicing physician fee; $265 - physician-in-training fee; $85 - single day attendance. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 21 hours of Category I Credit.

Date: February 12, "Therapeutic Drug Monitoring." Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** Willys F. Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours of Category I Credit.

Date: Feb. 13-19, 1983, Myocardial Infarction and Angina Pectoris. Location: Davos, Switzerland. **Sponsor:** Division of Cardiology of the Hannover Medical School, Hannover, West Germany, and the University of Michigan. **For:** All physicians and surgeons with an interest in ischemic heart disease. **Cost:** $300. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center for CME, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 28 hours of Category I Credit.

Date: Feb. 23-March 1, 1983, Adolescent/Young Adult Medicine. Location: Wailea Beach Hotel, Maui, Hawaii. **Sponsor:** Hurley Medical Center, Department of CME. **Contact:** Hurley Medical Center, Dept. of CME, One Hurley Plaza, Flint 48502, (313) 766-0142. **Approved for:** 20 hours of Category I Credit.

Date: Feb. 27-March 3, New Horizons in Oncology: A Clinical Update. Location: Kona Surf, Hawaii. **Sponsor:** U-M Medical School, Office of CME, Dept. of Postgraduate Medicine and Health Professions Education and the Division of Hematology/Oncology, Department of Internal Medicine. **Cost:** $345. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 16 hours of Category I Credit.

Date: March 9-12, 1983, Neurological Emergencies: A Symptom-Oriented Approach. Location: The Saddlebrook Resort, Tampa, Florida. **Sponsor:** U-M Medical School Office of CME, Department of Postgraduate Medicine and The Section of Emergency Medicine, Department of Surgery. **For (specialty):** Emergency physicians providing emergency care for neurological problems and all health care professionals who encounter emergency situations on a daily basis. **Cost:** $295, $115 for single day attendance. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, Towsley Center, Box 057, University of Michigan, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 13.5 hours of Category I Credit.

Date: March 20-25, Radiology Seminar. Location: Sun Valley, Idaho. **Sponsor:** Oakwood Hospital, Dearborn. **For:** Radiologists. **Cost:** $300. **Contact:** Oakwood Hospital, Department of Radiology, Alan T. Hennessey, MD, (313) 593-7300. **Approved for:** 20 hours of Category I Credit.

Date: March 23, New Technology And Instrumentation In Obstetrics And Gynecology. Location: Saint John Hospital, 22101 Moross Rd., Detroit, 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Obstetrics & gynecology. **Cost:** Saint John Hospital Staff - $75; River District Hospital Staff - $75; Other Physicians - $100. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: April 8-10, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: April 20, Pediatric Acute Care. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Pediatric. **Cost:** Saint John Hospital Staff - $75; River District Hospital Staff - $75; Other Physicians - $100. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 18, Inflammatory Bowel Disease. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Surgery. **Cost:** Saint John Hospital Staff - $75; River District Hospital Staff - $75; Other Physicians - $100. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Medicine, MSU, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine, Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 15, Family Practice Update II, 1983. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Family Practice. **Cost:** Saint John Hospital Staff - $75; River District Hospital Staff - $75; Other Physicians - $100. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 21-23, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: Nov. 1-3, 1983, Real-time Ultrasound Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: May 22-24, 1984, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

DEATHS

Jacques H. Ahronheim, MD
Jackson, Michigan

Jacques H. Ahronheim, MD, Jackson, died October 10 at the age of 75. Doctor Ahronheim was a 1918 graduate of Friedrich-Wilhelms Universitaet, Berlin, Germany. He was a member of the Army Medical Corps. from 1942-46. A chief pathologist for 33 years, he was affiliated with Foote Hospital, Jackson and Bixby Hospital, Adrian. Doctor Ahronheim enjoyed membership with the American Society of Clinical Pathologists, College of American Pathologists, American College of Physicians and the Michigan Pathological Society.

Clarence E. Crook, MD
Harbor Springs, Michigan

Clarence E. Crook, MD, Harbor Springs, died October 5. He was 75. Doctor Crook, a cardiovascular researcher, was a 1930 graduate of the University of Nebraska Medical School. He was affiliated with St. Joseph's Mercy Hospital where he established a research lab, the Beyer Memorial Hospital, Ypsilanti, and the Saline Community Hospital. Doctor Crook was a member of Phi Chi Medical Fraternity; a fellow, American College of Surgery, and a founding member of Frederick A. Coller Surgical Society. He was a surgery instructor at the University of Michigan Medical School until retirement.

Clarence D. Barrett, Sr., MD
Ann Arbor, Michigan

Clarence D. Barrett, Sr., MD, Ann Arbor, died September 22 at the age of 92. Doctor Barrett, former director of the Monroe County Health Department from 1953-62 and interim director in 1969, was "City of Monroe Physician" from 1953 until 1960 when the position was abolished. He received his MD from Ohio State University Medical School in 1914. He was an officer with the American Expeditionary Forces for 20 months in France during World War I and was health commissioner for various Ohio counties after his military service. Doctor Barrett was the director of the Bureau of Communicable Disease for Michigan Department of Health from 1931-38. He was first director of Ingham County Health Department from 1938 to 1946, then assistant health officer of Wayne County Health Department from 1947-49. Doctor Barrett was president of Monroe County Medical Society from 1957-58, first president of Michigan Health Officers Association in 1946 (he received a MHDA Distinguished Service Award in 1961), and past president of Michigan School Health Association.

Sydney S. Berke, MD
Detroit, Michigan

Sydney S. Berke, MD, Detroit, died September 16. He was 80. Doctor Berke had been a Detroit area surgeon for 56 years and was former chief of staff at Deaconess Hospital, Detroit. He also was affiliated with Doctor's Hospital. He received his MD from the University of Michigan in 1926. Doctor Berke was a founding member of the Standard Club, member of the State Selective Service Board and member of the International Academy of Proctology and International College of Surgeons.

Phillip J. Dommisse, MD
Grand Rapids, Michigan

Phillip J. Dommisse, MD, Grand Rapids, died October 6. He and his wife, Ruth, were killed in a car crash. He was a staff member of obstetrics and gynecology at Butterworth Hospital and had been in private practice in Grand Rapids for nine years. Doctor Dommisse served in the Army Medical Corps for two years as a captain after graduating from the University of Michigan Medical School in 1967.

John F. Engstrom, MD
Flint, Michigan

John F. Engstrom, MD, Flint, died September 29 at the age of 37. Doctor Engstrom was a gastroenterologist and former head of the alcoholism unit at Hurley Medical Center. He was a staff member of Hurley, St. Joseph, McLaren, and Genesee Memorial Hospitals. After graduating from Ohio State Medical School in 1970 he served the U.S. Army from 1972-74. He was a member of the Board of Directors of Genesee Health Care. Doctor Engstrom was a member of the American College of Physicians, Midwest Society of Gastrointestinal Endoscopy and the American Society of Gastrointestinal Endoscopy.

Junius W. McClellan, MD
Flint, Michigan

Junius W. McClellan, MD, Flint, died September 30. He was 65. Doctor McClellan received his medical degree from the University of Utah College of Medicine in 1949. He practiced occupational medicine at Buick Motor Division and was affiliated with Hurley Hospital. Doctor McClellan was a member of the Industrial Medical Association, Michigan Industrial Medical Association, and Phi Rho Sigma Medical Fraternity.

Lloyd L. Olsen, MD
Jackson, Michigan

Lloyd L. Olsen, MD, Jackson, died October 6. He was 66. Doctor Olsen received his medical degree in 1947 from the Medical College of Virginia and was a member of Alpha Omega Alpha honorary fraternity. During WWII he served in the Army Medical Corps; he also served with a hospital unit during the Korean conflict. Doctor Olsen taught anatomy at the University of Michigan for one year before completing his surgical residency. He was a member of the American College of Surgeons and was a fellow of the Frederick A. Coller Surgical Society. Doctor Olsen was affiliated with Foote Memorial and Mercy hospitals in Jackson and enjoyed membership with the Chamber of Commerce, Lions Club, Civil Defense Board, and the American Cancer Society.

Richard L. Waggoner, MD
St. Louis, Michigan

Richard L. Waggoner, MD, St. Louis, died September 20. He was 82. Doctor Waggoner was a mid-Michigan high school principal for several years before going to medical school. He received his medical degree in 1934 from the University of Michigan medical school. Doctor Waggoner set up a general practice in St. Louis in 1934, where he practiced until 1979. He was a member of the Advisory Board, Chemical Bank & Trust, St. Louis; St. Louis Lions Club; a life member of St. Louis F & AM Lodge 188, and the Phi Beta Pi Medical Fraternity.

Certifying physician competency

The important issue of measuring and certifying physician competency is the subject of the following article, which is an executive summary of an important position paper adopted September 9 by the MSMS Council. The paper was written by members of the MSMS Task Force on Physician Competency, chaired by Robert J. Toteff, MD, Detroit, to assist the Michigan Board of Medicine in carrying out its Public Health Code mandate to assess physician competency prior to licensing. On the basis of this paper, the MSMS Council September 9 recommended that the state establish mechanisms to measure physician incompetency, a more manageable task than to try to certify the competency of all licensed MDs in the state.

As the Public Health Code (Public Act 368 of 1978) was being drafted, the issue of licensure and certification of health manpower received much attention. One aspect of this issue was the responsibility of the state to assure the competency of physicians (and other health care providers) as a condition of initial licensure and relicensure. Although it was agreed that licensure and relicensure should be contingent on the competence of the applicant, the mechanisms to assess the competence of the various health professions were not adequately developed to permit implementation of the concept.

In an effort to preserve the concept of relicensure based on a demonstration of continued competency, while permitting the necessary study and experimentation, the Michigan legislature included the following language in the Public Health Code:

"Section 16205 (2) Not later than six years after the effective date of this part, a board shall promulgate rules to establish a system of assessing, at intervals of not more than four years, the continued competence of licensees as a condition of periodic license renewal.

"Section 16208 (1) A board may establish a pilot program to develop a mechanism for assessing the continuing competency of licensees during the six-year period as specified in section 16205. The council shall serve as an advisory and coordinating body to the boards and department for pilot programs established under this section."

This provision applies to all 11 health professions licensed under the Public Health Code. The six-year period of experimentation expires on October 1, 1984. Due to the state's financial situation, there have been no funds allocated to conduct pilot programs.

MSMS action

Recognizing the dilemma of the Michigan Board of Medicine and the impact of the continued competency issue on physicians, The Council of the Michigan State Medical Society created a Task Force to investigate the issue of continued competency for physicians. The first role of the Task Force was to develop a definition of physician competency. The definition agreed on is as follows:

"Physician competence is the function of an array of attributes which compose a pattern of effective activity directed toward the health care and well-being of people as individuals or as groups. Three essential dimensions are usually recognized and encompassed:

"A. Knowledge: Factual knowledge and understanding relating to the function which the physician is called upon to perform.

"B. Abilities which include:

1. Communication skills
2. Technical skills
3. Self-discipline and work habits
4. Professional attitudes

"C. Clinical judgment: The capacity to apply the appropriate knowledge and skills at the right time. Included in this is the synthesis of hypotheses from the data and the appropriate testing of those hypotheses."

At present there is no single mechanism that can assess all aspects of physician competency. There are various mechanisms that are designed to assess the individual attributes comprising physician competency. Some of these mechanisms are objective and others are subjective. Because of the complex nature of physician competence, and because performance standards are not yet developed for most physician activities, the Task Force assumes that a competency assessment mechanism for physicians must include objective and subjective components. Michigan's current physician licensure mechanism sets a precedent for the dichotomous approach. The applicant is given a written test, (objective component), and is required to successfully complete one year of supervised postgraduate studies (subjective component).

In an effort to identify a mechanism or mechanisms to assess physician competency, the Task Force reviewed objective and subjective mechanisms. Some of these mechanisms were designed to study physician behavior. Others were designed as educational devices. Some were designed as competency assessment mechanisms for physicians. All are allged to have some ability to be utilized for competency assessment purposes.

Mechanisms to Measure Knowledge

Continuing Medical Education

Because of the agreed-upon need for physicians to undertake continuing medical education to maintain competency, and because of its mandatory status in Michigan, this mechanism has received much attention. The purpose of continuing medical education is to present factual information to permit the physician to stay abreast of developments in the rapidly advancing medical sciences.

There are volumes of literature on the subject of continuing medical education. The problem with continuing medical education as a competency assessment mechanism is the demonstration of its correlation to positive patient outcomes (validity). This weakness has been frequently cited by critics. In response to these criticisms there have been attempts to measure the effectiveness (ability to change patient outcome) of continuing medical education. Thus far, these studies have provided promising but scanty support for the validity of continuing medical education.

Although continuing medical education is essential to maintain competency, it does not assure competency or assess competency. Although there is a small body of studies showing that it can be valid as an educational tool, there is no substantial proof of validity as a competency assessment mechanism.

Self Assessment

The self assessment mechanism is an inventory designed for physicians to evaluate the strengths and weaknesses of their knowledge base. These tests are administered on a voluntary basis, usually by a specialty organization, and usually include an overview of recent advances in the medical care practices of the specialty area. The assumption is that the physician will then take continuing medical education in his/her area of weakness. The self assessment mechanism is not currently designed to function as a competency assessment mechanism and studies have not been conducted to test the validity of this mechanism for competency assessment.

Testing

The concept of comprehensive testing is widely discussed as a competency assessment mechanism because it is commonly assumed that a physician's initial competence for licensure purposes is solely based on such a test. This assumption is erroneous. The physician's mastery of a scientific knowledge base is determined through a written test, but the other attributes of competency (abilities and clinical judgment) are assessed through a one-year period of peer review before a full license is issued. While it is possible to assess a physician's scientific knowledge base through written or oral testing, this mechanism has decreasing applicability as the physician spends more years in medical practice.

The longer a physician practices, the more specialized his/her scientific knowledge base becomes. While a comprehensive examination for scientific knowledge is appropriate for the medical school graduate, it becomes increasingly less appropriate with the length of time a physician has been in practice. Therefore, a comprehensive test of scientific knowledge is not a valid competency assessment mechanism for two reasons: (1) the relationship between a physician's scientific knowledge base and competency has not been demonstrated, and (2) there are many competent physicians who would not be able to pass a comprehensive test of scientific knowledge (low validity due to falsely negative results).

Specialty Society Certification

In 1973 the American Board of Medical Specialties agreed that persons certified by specialty boards should undergo periodic recertification. The specialty boards agreed with this concept. As of July 1981, 11 specialty boards had approved mechanisms to recertify their members. Some state licensing boards have adopted specialty board certification as a demonstration of competency for purposes of relicensure. At first glance, this mechanism seems to overcome the need to develop specialized tests that are applicable to specialized types of practice. However, this approach has two major faults.

The first fault concerns the purposes of physician licensure and specialty certification. The purpose of physician licensure is to assume that the physician possesses at least minimum levels of the knowledge, skills, and clinical judgment to practice medicine. The purpose of specialty certification is to demonstrate that the physician has voluntarily achieved a level of excellence within a specialty area of medical practice. Much has been published regarding purposes and limitations of specialty certification, but the concept is still poorly understood by the public and widely misused. The American Medical Association does not hold specialty certification as a guarantee of possessing the minimal competence required for licensure and urges that state licensure boards not use specialty certification for this purpose.

The second fault in utilizing specialty certification as a measure of competency are the questions arising about the reliability and validity of the testing procedure. Studies have been conducted that demonstrate the weaknesses in specialty certification as a method of assessing physician competency. The problems commonly pointed out are: (1) the examinations are given without a definition of what constitutes competency, (2) the examinations are largely a test of the physician's recall ability, and (3) there is a range of variability in the examiners, their perception of competence, the material used for testing and the approach to evaluation. The tests for specialty certification are still in their infancy and are not yet valid for general competency assessment purposes.

Conclusions

Although it is possible to comply with the letter of the law and assess competency as a condition of relicensure, the Task Force found no mechanism or combination of mechanisms that would meet the criteria for a meaningful competency assessment, i.e., valid, practical and cost efficient. The lowest cost approaches have the disadvantage of having little or no validity. More complex approaches, such as computer simulations and multi-mechanism approaches utilized for specialty society recertification have higher validity but are not yet sufficiently valid and are too costly and/or time consuming to be utilized for relicensure purposes. Therefore, the task force concludes that the state of the art of physician competency assessment is not yet adequately developed to rely solely on competency assessment as a condition of physician relicensure.

The Task Force believes that the state of the art of physician competency assessment may develop to the point that it can be used for relicensure purposes. The most promising approaches are the multi-mechanism approach (developed for specialty society recertification), and the computer simulations to assess clinical judgment. The strength of the multi-mechanism approach is that it assesses several of the attributes which comprise competency. The promise of the computer simulation is that increasing amounts of health data are computer readable.

FOOTNOTE

This Continued Competency Report is, in actuality, a literature review.

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DOCTORS NEEDED in Wisconsin and Minnesota, all specialties, all locations. For confidential information, mail your C.V. to Medicus, W62 N281 Washington Avenue, Cedarburg, Wisconsin 53012.

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Vincent P. Russell, MD
Pleasant Ridge

Vincent P. Russell, MD, Pleasant Ridge general practitioner for more than 50 years, died September 2. He was 76. He graduated from the Detroit College of Medicine in 1932, and was a past president of the Oakland County Medical Society. Doctor Russell was affiliated with William Beaumont and St. Joseph Hospitals, and was a fellow of the American Academy of Physicians.

Donald H. White, MD
Grosse Ile

Donald H. White, MD, Grosse Ile, died August 31 at the age of 61. Doctor White had been affiliated with Wyandotte General Hospital for 31 years, and had held several staff offices there. He also maintained an Internal Medicine practice in Lincoln Park and was regarded as a heart specialist. A 1945 graduate of the U-M Medical School, Doctor White was a member of the American College of Physicians and the American Society of Internal Medicine.

By James H. Tisdel, MD
MSMS President

Some answers to the question of why health care costs so much

In the September issue of *Michigan Medicine*, Doctor Tisdel discussed the common accusation that physicians are responsible for high health care costs. He explained that physicians really have control over only 20 percent of the costs. In this column he continues to discuss some of the reasons for high health care expenditures. These columns are taken from the addresses Doctor Tisdel has been making to component medical societies.

Cancer is the number one drain on all our health care resources. It strikes all ages, but as our population grows older, more develop this disease. Countless studies have linked tobacco as a major factor in its development; yet government subsidizes the tobacco industry, and millions are spent yearly in advertising to encourage people to take up the habit as something desirable and sophisticated. People contribute to their own health downfall, and we physicians sit back and take blame for the high cost of health care. Cancer of the lung is the number one cause of cancer deaths in males. By 1984, ACS tells us it will be the number one cause of cancer deaths in females, replacing breast cancer. Doctors do not cause cancer.

Motor vehicle accidents are second in the drain on health care dollars. The National Safety Council says some 57,000 people were killed on our highways last year from cars, motorcycles and mopeds. Plus, 3,000,000 were injured — nearly half of them young adults aged 16-24. Two million required hospitalization for days, weeks, or months — as they needed the use and reuse of our highest technology and services of multiple specialists in almost all fields of medicine.

Burns — two million burns occur each year — 50 percent involving children who 80 to 90 percent of the time receive their injuries in their own homes. Eight thousand die; but for those who live, burns constitute some of the most severe and costly of all injuries. As in cancer, the families ask doctors to do all they can to please try everything and not spare any expense.

Drugs — Though much is said about marijuana, LSD, cocaine, and heroin — the number one drug causing medical and social problems of all kinds is alcohol. It is implicated in half of all auto fatalities. It is involved in many leading causes of death in persons under 45 — namely accidents, homicides, and suicides — and several thousand burn victims are those who fall asleep while smoking under the influence of alcohol.

As long as free people remain free to drink to excess, eat to excess, drive too fast and smoke, we can expect the costs of health care to continue to rise. And we will be called upon to use all our knowledge and skill to repair the damages, problems largely preventable by an educated, enlightened, and motivated public.

This gives us some answers to those who want to know why medical care — all health care — costs so much. We can remind them that only 19 to 20 cents of each dollar spent on health care goes to physicians and 50 percent of that money goes to our operating overhead — our cost of doing business.

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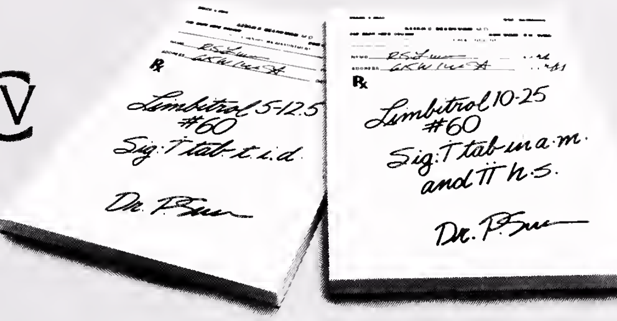

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In anxious depression,

SPECIFIC FOR THE NONPSYCHOTIC PATIENT

Fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician[1] found a correlation of 0.7 in anxiety and depression scores; another[2] has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

More appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression that contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.[2,3]

Avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and other extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970. **2.** Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* edited by Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **3.** Baldessarini RJ, Tarsy D: Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress,* edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p. 999.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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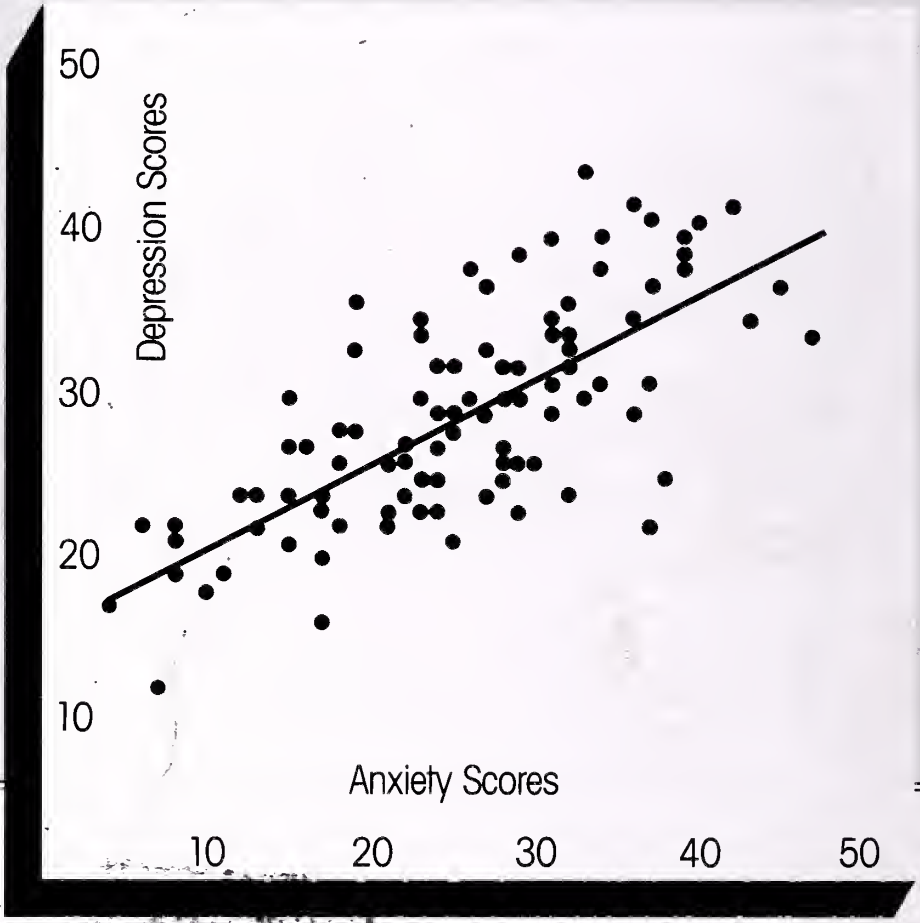

The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scale in 100 nonpsychotic psychiatric patients. The Coefficient of Correlation is 0.7. As depression increased, so did the anxiety levels.
—Adopted from Claghorn J[1]

A key reason why
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1. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970

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